ASSESSING THE STATUS OF MALE INVOLVEMENT IN FAMILY PLANNING IN THE PHILIPPINES

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ACRONYMS

ADS	Automated Directive System
AED	Academy for Educational Development
ARMM	Autonomous Region of Muslim Mindanao
ASM	Advocacy and social mobilization
BCC	Behavior change communication
BHW	Barangay health worker
BTL	Bilateral tubal ligation
CA	Cooperating agency
CBA	Collective bargaining agreement
CBMIS	Community-Based Monitoring and Information System
CCUVA	Cebu City Urban Vendors Association
CEDPA	Center for Development and Population Activities
CHO	City Health Officer or City Health Office
CMS	Commercial Marketing Strategies project
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
DKT	Darmendra Kumar Tyagi
DND	Department of National Defense
DOH	Department of Health
EnRICH	Enhanced and Rapid Improvement of Community Health
FFW	Federation of Free Workers
FGD	Focused-group discussion
FP	Family planning
FPOP	Family Planning Organization of the Philippines
FPS	Family Planning Survey
GAD	Gender and development
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IGWG	Interagency Gender Working Group
IPOPCORM	Integrated Population and Coastal Resource Management
IR	Intermediate result
IRH	Institute of Reproductive Health
IUD	Intrauterine device
KAP	Knowledge, attitudes, and practice
KATINIG	Kalipunan ng Maraming Tinig ng Manggagawang Impormal
KBP	Kapisanan ng mga Broadcasters ng Pilipinas
Kg	Kilogram
LEAD for Health	Local Enhancement and Development for Health
LGU	Local government unit
MSH	Management Sciences for Health
MCH	Maternal and child health
Metro Cebu CAN	Metro Cebu Community Action Network
MHO	Municipal Health Officer or Municipal Health Office
MIU	Men in Uniform

MRL	Muslim religious leader
MWRA	Married women of reproductive age
NACTODAP	National Confederation of Tricycle Operators and Drivers Association of the Philippines
NCR	National Capital Region
NDCP	National Defense College of the Philippines
NDHS	National Demographic and Health Surveys
NEDA	National Economic and Development Authority
NeOFPRHAN	Negros Oriental /Reproductive Health Advocacy Network
NFP	Natural Family Planning
NGO	Non-governmental organization
NSO	National Statistics Office
NSV	No-scalpel vasectomy
OC	Oral contraceptives
P	Philippine peso
PBSP	Philippine Business for Social Progress
PEBRMNet	Philippine Evidence-Based Reproductive Medicine Network
PHC	Primary health care
PHO	Provincial Health Office or Provincial Health Officer
PhilCOS	Philippine Community Organizers Society
PhilHealth	Philippine Health Insurance Corporation
PLCPD	Philippine Legislators' Committee on Population and Development
PLGM	Philippine League of Government Midwives
PNGOC	Philippine NGO Council for Population Health and Welfare
PNP	Philippine National Police
POPCOM	Commission on Population (Philippines)
PopNet	Population Network
PRISM	Private Sector Mobilization for
RH	Reproductive health
RHM	Rural Health Midwives
RTG	Research and Technical Group
SDM	Standard days method
STI	Sexually transmitted infection
TNS Trends	Taylor Nelson and Sofres (market information organization)
TSAP-FP	The Social Acceptance Project – Family Planning
TODA	Tricycle Operators and Drivers Association
TUCP	Trade Union Congress of the Philippines
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAWC	Violence against women and children
VSC	Voluntary surgical contraception

CONTENTS

Page

EXECUTIVE SUMMARY

OVERVIEW

The United States Agency for International Development (USAID) Mission has decided to review options in the near term to develop and/or expand existing programs to include men in (FP) both in support of their partners and as users of FP methods. A three-week assessment of the status of male involvement in FP in the Philippines in February 2005 found substantial recent and ongoing activities in research, policy guidelines, information/education/communication (IEC) and social mobilization as well as service delivery. The assessment findings indicate that strategies to involve men in FP, albeit not currently implemented on a large scale, are feasible and warrant USAID mission support.

ASSESSMENT CONTEXT

There is evidence that working with men (especially with women in a couple approach) in family planning can result in improved outcomes. USAID's Interagency Gender Working Group (IGWG) has recently developed resources that justify including men in FP and has documented promising program examples. Quantitative evaluative research demonstrates that involving men in FP programs can improve contraceptive acceptance, continuation, client satisfaction and efficacy. Given these encouraging findings, the Philippine FP program may benefit from the implementation of practical and culturally rooted strategies to involve men in FP.

CAVEATS AND GENDER FRAMEWORK

Important caveats should be considered when trying to include men in FP. Male participation in FP should be "constructive." This means it should always protect women's interests and not reinforce traditions of male dominance. Programs to include men in FP should not divert resources from existing programs for women. This assessment is based on a gender-equity framework that emphasizes a partnership between men and women in decision-making and endorses an educational approach to sensitize men about male and female gender roles and their consequences.

USAID POPULATION, HEALTH AND NUTRITION RESULTS FRAMEWORK

This assessment addresses USAID's Population and Health Program Strategic Objective 3 (SO 3): "Desired Family Size and Improved Health Sustainably Achieved" as well as the intermediate results associated with SO 3. The constructive involvement of men in FP has potential to help improve the efficient, effective, and sustainable delivery of health and FP services in the local government and the private health sectors. Working with men can result in greater social acceptance of FP as well as an improved policy environment and financing for services.

ASSESSMENT OBJECTIVES

Results of the assessment are to be used as inputs to strengthen male involvement in FP communication and service delivery activities in the country. The objectives of the assessment are:

1. To gather, review and do an in-depth analysis of studies and related literature that have been done on Filipino males and FP in the Philippines;

2. To review current program and operational policies and guidelines and determine how they are enhancing or discouraging grater male participation in FP;

3. To assess FP projects and activities and attempts, if any, to consider men in the design and implementation of these projects and activities; and

4. To identify strategies and practices that are friendly and/or unfriendly to men to come up with appropriate recommendations to encourage/strengthen male participation in current communication and service delivery activities. These shall include, but shall not be limited to: identifying male-specific FP messages including male-friendly IEC and counseling strategies and approaches; and effective FP service delivery programs for males.

METHODS

The assessment team reviewed pertinent project documents. In-country work included: extensive meetings with USAID's OPHN Chief and other OPHN staff and interviews with local staff of selected USAID-supported cooperating agencies, representatives from selected donor agencies, government and non-government organizations, the academe and other local partners and experts. Field trips were taken to do informal and in-depth interviews and focus group discussions (FGDs) with both male and female clients and service providers. Four FGDs were conducted, two with no-scalpel vasectomy (NSV) client couples, one with standard days method (SDM) client couples, and one with men in the military. A review and in-depth analysis was conducted of current program and operational policies and guidelines, relevant studies, including National Demographic and Health Survey (NDHS) reports and annual Family Planning Survey (FPS) reports, as well as recent unpublished qualitative and quantitative research.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Research

While some high quality data are available on both adolescent and adult men, the assessment of available research found there is still a lack of representative data on men, especially related to knowledge, attitudes, FP behaviors, as well as data on services for men. There is no strategic research plan for men and FP, little systematic documentation, and ineffective use of research for monitoring male services (lack of gender desegregation).

Research Recommendations (See Section VII for implementing details.)

- Rationalize the men and FP research agenda, and strengthen and evaluate the use of research findings in programs and projects by supporting the creation and operation of a research and technical group (RTG) to spearhead a systematic identification, definition and justification of research priorities.

- Invest field support funds into the MEASURE/NDHS project for an in-depth secondary analysis of existing data on men and FP with special emphasis on the results from NDHS 2003 Male Module.

- Implement short-term high priority research and OR studies through centrally-funded research mechanisms such as the FRONTIERS project and the Contraceptive Research, Technology, and Utilization (CRTU) project.

Policy and Guidelines

Important findings include opportunities stemming from gender-related clauses within government policies across sectors, especially within the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth) as integral partners in continued efforts to increase NSV access in accredited facilities. Innovative policies exist beyond the scope of DOH (e.g., military, labor force). Priority policy recommendations include:

Short-Term Policy Recommendations (See Section VII for implementing details.)

- Designate and fund a USAID cooperating agency (CA) or qualified local agency with policy experience to systematically support relevant policy guidance initiatives.

- Implement a Policy Analysis Forum to build on previous efforts of the Philippine NGO Council (PNGOC) and bring together stakeholders from public and private sectors to discuss opportunities and constraints for male involvement in FP within policy guidelines and protocols.

- Organize NSV service providers as a group to work with the DOH to streamline requirements and procedures for accrediting NSV service providers, NSV facilities, and even clinical practice guidelines or protocols.

- Create guidelines for male policy leaders in support of men and FP.

Long-Term Policy Recommendations

- Designate a USAID CA or local agency to take responsibility to highlight benefits of men and FP approach in dialogues with national government.

- Designate and fund work by a USAID CA or local agency to work to expand PhilHealth's role in supporting services for men and FP.

IEC/Behavior Change Communication (BCC) and Social Mobilization

The review of IEC/BCC and social mobilization activities identified promising approaches and many practical suggestions for improving communication strategies to encourage men in FP. Priority IEC/BCC and social mobilization recommendations include:

Short-Term IEC/BCC and Social Mobilization Recommendations (See Section VII for implementing details.)

- Fund continued work with Muslim Religious Leaders (MRLs) to develop male/couple-oriented mass media materials to capitalize on successes following the launching of the national fatwa on FP and reproductive health.

- Fund, or tap available resources from USAID Interagency Gender Working Group (IGWG), to conduct training programs for the management and technical staff of social marketing and related mass media agencies to increase their knowledge and awareness of gender-equitable approaches to marketing and monitoring results.

- Expand the use of IEC/BCC and social mobilization messages for men and FP that address men's concern for the economic realities of supporting a large family.

- Extend mobilization with male groups, such as tricycle associations, men in uniform (MIU), and MRLs with emphasis on linkage to FP services and an adaptation of the Community-Based Monitoring Information System (CBMIS) approach to identify unmet need. (This recommendation is shared by the service delivery assessment.)

- Use culturally familiar local and influential public figures for FP messages; enrich IEC handouts and posters with high quality materials that reflect local culture and language.

- Use a couple approach to highlight success stories of satisfied couples and users through personal testimonies both locally and through the media.

- Conduct a training needs assessment for different levels of FP planning service delivery, from provincial hospital down to Barangay Health Station, to develop a culturally appropriate training program that will help sensitize both public and private sector FP service providers for working with men in FP.

- Fund promising programs for both in-school and out of school youth that reach young men.

Long-Term IEC/BCC and Social Mobilization Recommendations

- Encourage expanded use of assets-based community social mobilization approaches with a focus on couples as developed by Save the Children and the Integrated Population and Coastal Resource Management (IPOPCORM) project.

Service Delivery

FP services need to be tailored to meet the needs of men at different life stages. Major findings from the review of services include the value of CBMIS for identifying unmet need to reach and recruit men; the importance of assuring quality of FP services, and the need to expand mechanisms for financing male FP. Priority service delivery recommendations include:

Short-Term Service Delivery Recommendations (See Section VII for implementing details.)

- Ensure that social acceptance mobilization protocols with large agencies (such as trade unions that serve men) include planning to develop links to tangible FP services. If feasible, this should be combined with efforts to adapt CBMIS approaches to identify unmet need within the membership of these agencies.

- Facilitate NSV specialist outreach and establish more Philhealth-accredited NSV facilities.

- Consolidate the number of qualified NSV providers through refresher training and expanded to new practitioners.

- Expand subsidies and PhilHealth reimbursements both within existing PhilHealth-accredited sites and by expanding primary care NSV sites through licensing and accreditation.

Long-Term Service Delivery Recommendations

- Fund the expanded use of CBMIS at local government unit (LGU) as an important strategy to reach men.

- Highlight the male involvement in FP approach through expanded subsidy of male methods with assistance from donors, national agencies, LGUs and the private sector.

I. BACKGROUND

CONTRACEPTIVE USE IN THE PHILIPPINES

Current use of effective FP methods, as reported by women in the 2003 NDHS, remains disappointingly low despite three decades of FP program effort. Use of modern methods is a modest 33.4 percent (NSO ORC Macro, 2004). An estimated one-fourth of women with a demand for FP are not using contraception. Rather than decline over time, the percentage of births reported as unwanted has increased by more than 10 percent over the past five years, from 18 percent in 1998 to 20 percent in 2003. On average, women's total wanted fertility (2.5) is exceeded by actual total fertility (3.5) or by one child, a discrepancy of 40 percent. In this alarming situation, male condom and male sterilization accounted for only 2.0 percentage points of FP use in 2003.

It is widely acknowledged that the Philippine FP program has focused almost exclusively on women and may have missed opportunities to effectively involve men to address these challenges (Lee and Dodson, 1998). Research findings from the Philippines show that men are influential gatekeepers for FP acceptance in the household and are an important client group for FP program efforts (Casterline et al,. 1997; Perez, 1997; Perez, 2000). Due in part to the lack of progress in the Philippine FP program, USAID programs have recently intensified efforts to include men in FP promotion and services (AED/TSAP-FP Presentation, February 8, 2005; MSH, 2003).

RATIONALE FOR MEN AND FAMILY PLANNING

Over the past decade, there have been increased efforts to include men in FP programs. This is the result of many factors, including the 1994 International Conference on Population and Development (ICPD) Plan of Action, the advent of the global HIV/AIDS pandemic, and the availability of high quality quantitative data on men from the NDHS (Ezeh et al., 1996).

There is evidence that working with men (especially with women in a couple approach) in FP and related reproductive health areas can result in improved health outcomes (Becker, 1996). USAID's Interagency Gender Working Group (IGWG) has recently developed resources that document health program justifications for including men in FP (IGWG Orientation Guide, 2002) as well as compelling program examples (IGWG Implementation Guide, 2005). Studies show that involving men can have significant benefits to FP programs for contraceptive acceptance, continuation, client satisfaction and efficacy (Fisek et al., 1978; Bhalerao et al., 1984; Terefe et al., 1993; Wang et al., 1998; Amatya et al.,1994). Given these encouraging findings, the Philippine FP program may benefit from the implementation of practical and culturally rooted strategies to involve men in FP.

Three important caveats should be considered when trying to include men in FP (AVSC, 1997; Clark et al., 1999). First, men's participation in FP should be "constructive"; that is, it should always protect women's interests and not reinforce traditions of male dominance. Second, involving men may require added expense and may mean competition for scarce resources. Programs to include men in FP need to add rather than subtract resources from

existing programs for women (AVSC, 1997). Third, efforts to involve men must be cost-efficient in terms of better outcomes in order to justify additional funds.

GENDER FRAMEWORK

This assessment of men and FP is based on a gender-equity framework that is the result of over 10 years of gender policy dialog, from the 1994 ICPD to recent work by the USAID IGWG (IGWG, 2002; IGWG 2005). There have been several important developments in gender frameworks within the Philippines, which are discussed below in Section IV. These include: the recent update of Gender and Development Guidelines (NEDA, 2003), a collaboration between EngenderHealth and the PNGOC (PNGOC Forum Document, 2002); the United Nations Population Fund (UNFPA) 5th country program (UNFPA RH training modules, 2000); and a recent examination of gender issues related to male involvement in reproductive health in the Philippines (Badiane, 2005).

Building on previous male involvement approaches (Cohen and Burger, 2000), this framework views men as equal partners of women but acknowledges that "gender inequities influence fertility behavior" (Badiane, 2005). The framework emphasizes a partnership between men and women in decision making, and encourages human rights for both men and women. It also proposes an educational approach to sensitize men about male and female gender roles and their consequences (Badiane, 2005; Cohen and Burger, 2000; Greene, 2003; Greene et al., 2000; Greene et al., 2004).

It is important to clarify how this framework is applied with concrete examples, as shown in Figure 1: A Continuum of Approaches for Gender Integration (IGWG, 2005). There is a range of approaches to FP activities to involve men that can be allocated to three categories: gender exploitative, gender accommodating, and gender transformative. As far as feasible, efforts to involve men should avoid the first two and attempt to use a gender transformative approach. Recent work by the Population Council Horizons program has shown that programs that work to help young men reflect on their gender identity and change gender norms can improve FP and sexually transmitted infection (STI) related knowledge, attitudes and behaviors (Barker et al., 2004; Pulerwitz et al., 2004).

Figure 1
Continuum of Approaches for Gender Integration

Gender Exploitative	Gender Accommodating	Gender Transformative
Programs that …exploit gender inequities and stereotypes in pursuit of project outcome. Often harmful in long-term and can undermine program objectives.	….accommodate gender differences to achieve project objectives. May make fulfilling gender roles easier but does not attempt to reduce gender inequality.	….seek to transform gender relations to promote equity and achieve program objectives by encouraging critical awareness of gender roles and promoting improved women's status.
Example: Condom social marketing campaigns that use aggressive or violent imagery to reinforce male decision-making power and control.	Example: Projects that take services to women who have limited social mobility; doorstep distribution of oral contraceptives (OCs) in Muslim society where women are in seclusion.	Example: Programs that work with young men and young women to challenge rigid gender roles.

Adapted from USAID IGWG Presentation, 2005.

USAID POPULATION, HEALTH AND NUTRITION RESULTS FRAMEWORK

The scope of work for this assessment responds to USAID's Population and Health Program Strategic Objective 3 (SO3): Desired Family Size and Improved Health Sustainably Achieved. SO3 has four intermediate results, which, if achieved, is believed to lead to the achievement of the strategic objective. The intermediate results (IRs) are:

- IR1: Local government unit (LGU) provision and management of FP/MCH/TB/HIV/AIDS services strengthened;
- IR2: Provision of quality services by private and commercial providers expanded;
- IR3: Greater social acceptance of FP achieved; and
- IR4: Policy environment and financing for provision of services improved.

The assessment is designed to address all four of the above intermediate results. It is asserted that the constructive involvement of men in FP has potential to help improve the efficient, effective, and sustainable delivery of health and FP services in the critical areas of local government and the private health sectors. It is anticipated that working with men may result in greater social acceptance of FP as well as an improved policy environment and financing for services.

ASSESSMENT OBJECTIVES

Results of the assessment are to be used as inputs to strengthen male involvement in the implementation of the FP communication and service delivery activities in the country. The objectives of the assessment are:

1. To gather, review and do in-depth analysis of studies and related literature that have been done on Filipino males and FP in the Philippines;

2. To review current program and operational policies and guidelines and determine how these are enhancing or discouraging greater participation in FP;

3. To assess FP projects and activities and attempts, if any, to consider men in the design and implementation of these projects and activities; and

4. To identify strategies and practices that are friendly and/or unfriendly to men and come up with appropriate recommendations to encourage/strengthen male participation in current communication and service delivery activities. These shall include, but shall not be limited to: identifying male-specific FP messages including male-friendly IEC and counseling strategies and approaches; and effective service delivery programs for males.

METHODS

Prior to the start of the assessment team's in-country work, staff from the OPHN of USAID/Philippines gathered relevant project documents and sent them to the members for review. In-country work included extensive meetings with the OPHN Chief and other OPHN staff, interviews with local staff of selected USAID-supported cooperating agencies, representatives from selected donor agencies, government and non-government organizations, the academe and other local partners and experts.

Field trips were taken from February 7 to 19 to do interviews and FGDs with various stakeholders, male and female groups including female and male FP service providers, MIU, MRLs, Standard Days Method (SDM) and NSV acceptors. Efforts were made to ensure both men and women clients were interviewed. FGD participants included 13 women and 15 men; approximately 65 men and 71 women took part in various information gathering meetings and interviews during the course of the assessment (Appendix G: Methodology and Documentation for Qualitative Data Collection, Appendix H: Results from FGDs and In-Depth Interviews). A review and in-depth analysis was conducted of relevant studies including NDHS reports and annual FP surveys, as well as recent unpublished qualitative and quantitative research.

II. BRIEF HISTORICAL OVERVIEW OF THE PHILPPINE FAMILY PLANNING PROGRAM AND MALE INVOLVEMENT STRATEGY

The Philippines officially launched its population program in 1970 through Executive Order No. 233. It strengthened the program by enacting the Population Act of the Philippines (Republic Act 6365) into law by Congress in 1971. Later, in 1972, Presidential Decree No. 79 was issued specifically directing private and public sectors to undertake a national FP program promoting contraceptive methods, including male and female sterilization, to Filipino couples of reproductive ages.

In its early years of implementation, the program recognized the pivotal positions and roles of men in decision making in the family and in the larger society. In the late 1970s, the program adopted a male involvement strategy that saw men assume the roles of community-based counselors and motivators, and advocates to promote FP methods. It was at this time that hundreds, perhaps even thousands, of Filipino men accepted vasectomy as one of the contraceptive methods being offered by the Philippine FP program. However, beginning in the middle of the 1980s through the early part of the 1990s, the implementation of the campaign for male involvement, as part of an overall effort to increase contraceptive use in the country, was sidelined by a host of factors and conditions such as religious opposition, social, economic and political upheavals, and natural disasters.

REVIVAL OF THE STRATEGY

Beginning the middle of the 1990s, the Philippines revived the strategy of male involvement bolstered by its commitment to national, global and international platforms of action seeking to improve women's status and health. Such a move was also inspired by the improved overall development climate and a renewed commitment to offer FP services. The re-emergence of male involvement can be linked to four distinctive developments.

- One, the rationale for such strategy is now aligned in the context of a gender equity framework.

- Two, current work has linked male involvement with not just FP but a range of issues including sexually-transmitted infections (STIs), maternal and child health (MCH), prevention and management of abortion, gender violence, prostate and testicular cancer, adolescent reproductive health, and infertility as subsumed under the broad term 'reproductive health'. In reality, though, public and private efforts have mainly involved men in the context of a few RH elements, most commonly STI and HIV/AIDS, FP, and gender violence. The health program of the Provincial Government of Nueva Vizcaya, however, is an exception. The province established a working committee at various administrative levels (provincial, municipal or barangay) for each of the 10 RH elements mentioned above.

- Three, the pursuit of male involvement is presently led by the community of nongovernmental and funding organizations whose base and foothold in the country's health matters and activities have considerably grown since the 1970s.

For example, we have Philippine NGOs like the Family Planning Organization of the Philippines (FPOP), Well-Family Midwife Clinics, and FriendlyCare; international FP support organizations like the Darmendra Kumar Tyagi (DKT), Management Sciences for Health (MSH), and Marie Stopes; and a network of NSV service providers.

- Four, the revival of the strategy is occurring at a time when the traditional gender role of many Filipino men as the sole financial provider in the family has weakened, as their female partners, conventionally confined within the household, have taken the added role of economic providers. Locally employed female workers increased by 62.2 percent in 2004 compared to the 1991 figure. Internationally, more women than men are now working overseas (69 percent versus 31 percent). Women's entry into the formal labor force has opened opportunities for the implementation of activities focused on gender equity in FP.

GROUNDWORK EFFORTS AND GAPS

Given the revitalized efforts to encourage men's participation, some modest accomplishments have been made. A 1998 national study was undertaken to determine and examine the status, challenges and prospects of male involvement in women's health initiatives (Lee and Dodson, 1998). A series of seminars and workshops were held, and culminated in the development of men's reproductive health strategic program framework (PNGOC, 2002; DOH, 2002). A number of small-scale and larger province-wide activities in research, communications, and service delivery have been likewise initiated and continued with support from the UNFPA and other organizations.

The Commission on Population (POPCOM) has identified 28 projects related to men and FP throughout the Philippines since 2000 (Table 1). There have been projects in eight regions as well as the NCR and Cordillera Autonomous Region. Of the 28 projects, nine have ended and 19 are ongoing, and five will end in 2005. Four projects are planned for 2005 or later. The full POPCOM matrix of programs is shown in Appendix D: Matrix on the Male Involvement in Reproductive Health and Family Planning (CY 2004/as of February 21, 2005). While Table 1 does not fully capture all work to involve men in FP throughout the Philippines (it ignores many other programs and projects that address male involvement in FP, such as by FPOP, the DOH FP program, DKT, etc.) it shows that a great deal of effort has been in progress. The projects indicated in Table 1, and described in Appendix D, are funded by multiple overlapping sources including local government units (LGUs) (ten projects), USAID through the Academy for Educational Development/The Social Acceptance Project – Family Planning or AED/TSAP-FP (seven projects), local and national Population Commissions (six), UNFPA (five), and entities like the Lions Club and Marie Stopes. Many projects involve advocacy and social mobilization efforts, while only a few involve FP service delivery. USAID and UNFPA are the main donor supporters of these men and FP activities.

Table 1
Men and FP Project for the Period 2000–05 by Region by Current Status

Region/ Status	NCR	CAR	Reg II	Reg III	Reg IV	Reg VII	Reg VIII	Reg IX	Reg XI	Reg XII	Total
Ongoing	4	1	2		2				3	2	14
Ongoing but to end in '05	1		1	1		1	1				5
Ended since 2000	4			2				1	1	1	9
Total Projects	9	1	3	3	2	1	1	1	4	3	28
Proposed Projects						2	1		1		4

Source: POPCOM, February 2005. See Appendix D: POPCOM Matrix on Male Involvement in Reproductive Health and Family Planning, 2005

Although impressive efforts to encourage male involvement have been pursued, they have tended to be sporadic. They do not form part of a unified, national and comprehensive program that would use the involvement of men to effectively improve the acceptance, efficacy, and continuation of the use of FP methods. The programs to involve men in FP implemented nationwide over the past decade have not been associated with a very favorable trend in contraceptive method mix. Male involvement in FP entails more than promotion of effective male methods and discouragement of the undue reliance on withdrawal. Nonetheless, over the last decade, condom use has increased by less than one percentage point, and the overall proportion of male methods (condom, vasectomy and withdrawal) has remained fixed at about 20 percent of methods used by married women (Table 2).

Table 2
Trends in Contraceptive Use (1993, 1998, 2003): Percent of Currently Married Women Using "Male" FP Methods Versus All Other Methods for FP in the Philippines and National Contraceptive Prevalence Rate (CPR)

Survey	"Male" Methods (Condom, Vasectomy, Withdrawal)	All Other Methods (Except Condom, Vasectomy, & Withdrawal)	Total All Methods	CPR All Methods	CPR Condom	CPR Vasectomy	CPR Withdrawal
1993 NDHS[1]	21.1	78.9	100.0	40.0	1.0	0.0 %	7.4
1998 NDHS[2]	22.8	77.2	100.0	46.5	1.6	0.1	8.9
2003 NDHS[3]	20.9	79.1	100.0	48.9	1.9	0.1	8.2

Sources: [1]1993 NDHS: ORC Macro 2005, MEASURE DHS STATcompiler. http://www.measuredhs.com, March 14, 2005; [2]NSO Table 7; [3]2003: NSO ORC Macro 2004.

III. CRITICAL ANALYSIS OF STUDIES AND LITERATURE ON FILIPINO MALES IN FAMILY PLANNING IN THE PHILIPPINES

The Philippines has limited empirical information and literature, both published and unpublished, on the subject of men in FP. Data have come from quantitative, large-scale surveys (NDHS, FPS, Cebu Longitudinal Health and Nutrition Study, Young Adult Fertility and Sexuality Survey, and Men's Study on Sexuality and AIDS) and to an extent, from qualitative studies (FGDs and key informant interviews) which have involved men, along with women, from various geographic locations across the country (more urban than rural). Based on a landmark study of 780 matched couples in rural and urban Philippines, researchers concluded that "men's views need to be taken seriously in the development of interventions to reduce unmet need in the Philippines" (Biddlecom et al., 1997). Almost one-fifth of unmet need among these Filipino couples could be attributed to husbands' negative perceptions (Casterline et al., 1997).

On the whole, the most commonly examined topics have been men's sexual behavior, and FP knowledge, attitudes and practices. Cognizant of the paucity of data on the broad topic of men in FP, the USAID Assessment Team collected additional qualitative data by conducting FGDs among FP acceptors of NSV (two FGDs), SDM clients and their wives (one FGD), MIU (one FGD), and key informants' interviews among service providers, the findings of which are also discussed in this section.

MEN'S SEXUAL BEHAVIOR AND FAMILY PLANNING

Based on a 1999 survey of men in three urban areas, most Filipino men aged 15-44 (84.1 percent) are sexually experienced predominantly in the context of a heterosexual relationship, beginning on average at the age of 18.8 (Ramos-Jimenez and Lee, 2001). Older, married and employed men are more likely to have sexual experience. Most of these urban men (87 percent) reported having only one sexual partner (their spouse) in the past year, and only 7.1 percent have intercourse with a sex worker. Nationally representative data for men age 15-49 in 2003 found that only 1.9 percent of men reported having intercourse with a sex worker in the past 12 months (NSO ORC Macro, 2004).

Men, as well as women of reproductive ages, are well aware and are in favor of FP. A 1993 survey in the Philippines found that men and women have similar views of contraception: 72 percent of husbands and 77 percent of wives strongly approved of contraception (Biddlecom et al., 1997). Based on the reports of women in the 2003 NDHS, men's desired family size is the same (67 percent) as or lower (7 percent) than the number of children desired by all married women (three children), a finding that is true for males from all age groups (NSO ORC Macro, 2004).

Table 3
Men's Knowledge of Family Planning Methods (in percentages)

Sex	Any Method Known	Any Modern Method Known	Any Traditional Method Known	Mean Number of Methods Known
Male	97.3	97.1	80.1	6.5
Female	97.9	97.6	83.2	7.9

Source: National Statistics Office, 2004.

As shown in Table 3 above, male knowledge of contraceptive methods is almost universal (97.3 percent). High percentages of males know modern male methods (95.4 percent for condom and 59.1 percent for male sterilization) and modern female methods (72.2 percent for female sterilization, 64.1 percent for IUD and 98.3 percent for pill). They have heard of contraceptive methods particularly condoms and pill from close friends, or acquaintances, television and health centers.

As reported by currently married women in 2003, negligible numbers of men are currently using effective male FP methods: only 0.1 percent were currently using male sterilization and 1.9 percent used condoms (NSO ORC Macro 2004). The level of unmet need among Filipino men is 45.7 percent[1], almost twice that of females (23.5 percent) (DOH, 2002). FP supplies are accessed from public facilities (hospitals, health centers and practitioners).

REASONS FOR NOT USING AND FOR USING FP METHODS

Qualitative evidence derived from the four assessment FGDs and a number of in-depth interviews indicated that men do not use a FP method for a variety of reasons: "wife is already using a method;" "wife is past her reproductive age;" one of them is "infertile;" they "want to have another child;" and they are not "interested." Men, along with health personnel, mention that FP clinics and the health centers, including the staff, are "not friendly" to men.

Vasectomy is not accepted because men say: "it causes loss of erection and ejaculation;" they are "afraid of being castrated;" "it affects one's mood which then affects sex life;" "it makes one gay;" "it makes one become a sex maniac;" "it is not appropriate for them because of their heavy work;" and "they will lose some days of paid work when they get sterilized."

Men use a FP method, "as an expression of their love to their wives and children;" "because of economic hard times as they have unstable jobs;" "recognition that the number of their children is increasing;" "they want their wives to be healthy as they are aware of the risks of pregnancy to them;" "they want to send their children to school;" and "because they want to give adequate attention to their children as they are also concerned and responsible for child care." Furthermore, men adopt FP because of their partners' encouragement, and "because it is a practice that he learned from his parents and grandparents."

[1] The figure refers to the men who do not want a child anymore or want to wait before having their next birth but are not using any method of FP.

Some men undergo vasectomy because: "the procedure is free;" "they are enjoined by testimonies of their vasectomized friends and relatives about the procedure;" "it is safe and free of harmful risks;" "the methods they previously used have failed;" "tubal ligation is not medically appropriate for their wives;" and "because of effective counseling and motivation of barangay health workers." Some men have deliberate discussions with their wives in which they compare vasectomy with tubal ligation, saying that the latter is more painful and complicated than the former, and thus posing greater risks to women. These vasectomy acceptors, thus, have the approval of their wives. But some husbands make their own decisions when they accept vasectomy.

PERCEPTIONS AND EXPERIENCES OF VASECTOMY ACCEPTORS AND THEIR WIVES

Results from the two assessment FGDs with NSV couples as well as in-depth interviews revealed that the period during which men decide whether or not to have vasectomy, in consultation with partner, parents and relatives, varies: as short as 1-2 weeks and as long as 6-12 months. The decision is quick when couples are convinced of the efficacy and long-term benefits of the procedure, and slow when couples still want assurance and more knowledge about its effects, like becoming "less of a man," which they later learn from vasectomized friends as unfounded.

Some male respondents reported having no problems (no fear and no pain) with the procedure. After the surgery, some mentioned tolerable numbness, explaining that it is a natural short-term effect of the procedure.

The NSV FGD couples reported that vasectomy has no effect on their sex life or on their sex drive. Although penile erection is normal, some men pointed out that the volume of their ejaculation has been reduced and has become more transparent. Greater sexual satisfaction is experienced by couples, especially the wives, because they have no fear of being pregnant. Frequencies of sexual intercourse even increased as it can take place "any day and any time." Couples say that their relationships are much closer and better after vasectomy, and they express willingness to share with others about its benefits.

As vasectomy acceptors, the men respondents think that they are different from non-acceptors because of their low-income status, and they have concern and aspirations for the needs of their families, particularly their children. The wives perceive their husbands who have vasectomy in highly positive ways. Acceptors will recommend the procedure to other men; in fact some of them are already promoting it.

Men and their wives suggest that in order to promote FP method use, it should be offered free, promoted by acceptors, highlight that "life is better" or "children are healthier" if there is FP, and that promotion should focus on dispelling myths and misconceptions.

MEN AND WOMEN'S PERCEPTIONS ON SDM

Professor Lita Sealza from the Research Institute for Mindanao Culture of Xavier University, who was interviewed on February 15, 2005, shared her six-month study among 29 couples in Malaybalay. Professor Sealza considers the Standard Days Method (SDM) to be gender equitable because it leads to open communication between husbands

and wives and the men become more disciplined because they understand why they must abstain from sex during fertile days. She found that husbands understood SDM very well and are knowledgeable about their wives' menstrual cycles. They even helped their wives move the necklace's rubber ring and in reminding which days are safe and unsafe for sex.

During fertile days, hardly any couple took sexual risks because they were aware of the consequences of their action. The couples' coping mechanisms to abstain from sex include: "sleeping in separate beds;" "turning their backs from one another while sleeping;" "wife allowing husband to drink alcohol to enable him to sleep right away;" and "wife wearing thick clothing and pants to protect herself from her husband's advances." According to the Malaybalay CHO-FP nurse, when some couples utilize other methods such as condoms or withdrawal during the period of abstinence, they are usually dropped from the program because they are no longer considered SDM users.

The accounts made by Professor Sealza and the CHO-FP nurse were validated by the answers of successful SDM couples at the office of Kaanib Foundation Inc., an NGO, on February 17, 2005. These respondents were purposively selected by Kaanib to participate in the FGD. The men acknowledged that they found the method very easy to understand, particularly their wives' menstrual cycle and the period of abstinence. The men and women felt their relationships with their partners have improved immensely since they started using the method because they were able to communicate about their sexual and family life. They added that they are better off economically, psychologically and socially as a result of their use of the SDM method. The wives said that they were no longer burdened and stressed because they do not worry about another pregnancy. The couples said that they were not going to use other permanent methods even if they have already reached their fertility goals because they are happy with SDM. Some couple farmers have in fact become peer volunteer motivators in their respective villages.

THE IMPACT OF MALE PEER COUNSELORS VERSUS FEMALE BARANGAY HEALTH WORKERS

Save the Children, in collaboration with DOH Region VI, the provincial health office (PHO) and municipal health offices (MHOs) in Iloilo province, conducted an FP intervention study to test and evaluate the effectiveness of involving male peer counselors and barangay health workers (BHWs) as educators and motivators of FP. It was expected that at the end of the year (1995), the project would have increased the CPR by two percent in the experimental areas compared to the control area. The project had four major components: training; field implementation/motivation; monitoring; and supervision as well as research. An evaluation found that the involvement of male peer counselors and BHWs has increased the CPR in the two experimental areas (23.3 percent in site one and 12.3 percent in site two) (David et al., undated). BHWs who were mostly women appeared to have performed slightly better than the male motivators; the latter needed close supervision. The evaluation noted that male motivators could have engaged more men to use male methods, particularly NSV, but this was not available in the research sites at the time.

ADOLESCENT MALE BEHAVIOR AND FAMILY PLANNING

National 2002 survey data for young men and women age 15 to 24 found that almost one-third of men and 16 percent of women reported sexual intercourse experience (Table 4), usually within the context of boyfriend-girlfriend relationships (Raymundo and Cruz, 2004). At first and last premarital intercourse, over one-fourth of young men reported use of contraception (Table 4), a higher proportion than reported by young women. The first method most commonly used included withdrawal, condom and the pill. At first and last premarital sex, condom use accounted for over 40 percent of method use (Table 4) reported by young men, higher than reported by young women.

Unpublished results for 2002 data for young men and women aged 17-19 collected in Cebu (Table 5) found that almost all men (92.2 percent) and women (96.5 percent) have heard of FP. Among those with sexual experience, over half of men (53.1 percent) and almost half of young women (46.8 percent) reported having ever used an FP method. Among the male youth who did not report use of an FP method, their chief reason was: "sex was unplanned and they do not know much about FP." Among females, the chief reasons expressed were: "not knowing much about or not liking to use an FP method."

The HIV/AIDS section of the 2003 NDHS includes important findings for never-married young men and women age 15-24. For example, rates of premarital intercourse, knowledge of and use of condoms (Table 6). Young men are far more likely than young women to report premarital intercourse in the last year (56.5 percent versus 1.7 percent), but there is not much difference between the two groups in knowing where to obtain condoms: about a third did not know where they could get them. Rates of condom use at first intercourse are quite high for young men (16 percent) compared to national rates of current condom use among currently married women (1.9 percent). Only a small proportion of these young men reported having more than one partner in the last year (six percent) or paying for sex (1.8 percent) (Table 6).

Table 4
Trends in Premarital Sex and Contraceptive Use Among 15-24 Adolescents: 1994 and 2002 (in percent)

Sex	Ever Had Premarital Sex		Practiced Contraception				Used Condom Among Those Who Used Contraceptive			
			During First Premarital Sex		During Last Premarital Sex		During First Premarital Sex		During Last Premarital Sex	
	1994	2002	1994	2002	1994	2002	1994	2002	1994	2002
Male	26.1	31.3	24.0	27.5	33.9	26.6	37.1	41.2	20.4	45.2
Female	10.1	15.7	(8.5)	14.9	13.0	21.8	(18.2)	38.0	(14.3)	23.3
Total	17.8	23.1	21.7	21.0	24.7	24.8	36.1	40.5	19.0	38.2
N of cases	1,940	3,850	210	1,930	220	3,547	205	405	40	3,513

Note: Percentages in parentheses are based on less than 30 cases.
Source: Raymundo and Cruz, 2004.

Table 5
Family Planning Knowledge and Practices Among 17-19 Adolescents (in percentages)

	Variables		
Sex	**Ever Had Sex**	**Ever Heard of Family Planning**	**Ever Used Family Planning**
Male	30.8	92.2	53.1
Female	19.5	96.5	46.8
Total	25.5	94.2	50.6
N of cases	523	1,932	266

Source: Cebu Longitudinal Nutrition and Health Survey, 2002.

MEN AND FAMILY PLANNING AS REPORTED IN THE 2003 NDHS

Dynamics of Condom and Withdrawal

Condom and withdrawal have been assessed for rates of continuation and efficacy in the 2004 NDHS report and they do not compare favorably with other FP methods. The rate of discontinuation for condom was the highest for all methods, 58.0 percent discontinued within one year. This compares to the average figure of 39.1 percent for all methods and 39.2 percent for the pill (Table 5.16 in NSO ORC Macro, 2004). This high discontinuation rate is compensated for in part by the fact that almost half of these condom users switched to another method (NSO ORC Macro, 2004, page 71). Condom failure rates in the first year were 7.9 perent compared to 7.8 percent for all methods and 3.7 percent for the pill. Withdrawal discontinuation and failure rates were 43.8 and 17.2 percent respectively. The most prominent reasons given for discontinuing condom were inconvenience of use (23.3 percent) and became pregnant while using (18.1 percent). The most prominent reasons for discontinuing withdrawal were: became pregnant while using (45 percent); and wanted to become pregnant (14.1 percent) (Table 5.17 in NSO ORC Macro, 2004).

Women's Low Demand for Male Methods

There is no evidence that women are clamoring to use male methods. The condom and withdrawal are not prominent as preferred methods among currently married women who are not using a contraceptive but intend to use a method in future. The most preferred future methods are the pill (48.1%) and female sterilization (9.7 percent) compared to only six percent for withdrawal, three percent for condom, and nil for male sterilization (Table 5.20 in NSO ORC Macro, 2004). A similar result is found for the preferred future method for currently married women with unmet need: less than two percent for condom and withdrawal and nil for male sterilization (Table 7.5 in NSO ORC Macro, 2004).

Low Husband Disapproval and Opposition to Family Planning

The role of the husband in contraception use is assessed by the NDHS in several ways based on reporting by women. Based on the 2003 NDHS, husband disapproval does not seem to be a major factor. Overall, husband disapproval accounted for only a small proportion of discontinuations for all methods (2.7 percent). The most important reasons stated for discontinuation are contraceptive failure, desire to become pregnant, and side effects (Table 5.17 in NSO ORC Macro, 2004). For specific methods, husband disapproval was greatest for male methods, but still low (5.5 percent for condom and 4.1 percent for withdrawal). Among married women who are not using FP, husband/partner

opposition accounts for only 3.7 percent of the reasons for non-use, less than half as much as the 8.8 percent opposition expressed by the women themselves. Key reasons for non-use include health concerns and fear of side effects (25 percent combined) (Table 5.19 in NSO ORC Macro, 2004).

Negotiation of Safer Sex

There was very close agreement between men and women concerning the right of a woman to refuse sex if her husband has STI (94.7 percent of women versus 94.1 percent of men) (Table 6). Remarkably, 97 percent of men agreed that the wife had a right either to refuse sex or to propose that her husband use a condom if her husband has STI (Table 6).

Table 6
Selected Results for Men and from the 2003 NDHS

Results from Selected Questions from the 2003 NDHS.	Women (Percent)	No. of Respondents	Men (Percent)	No of Respondents
Percentage of never married youth age 15-24 who report having sex in the last 12 month prior to survey (NDHS '03 Table 11.9)	1.7	(3,475)	56.5	(1,468)
Percentage of youth age 15-24 who report knowing of at least one source of condoms (NDHS '03 Table 11.8)	63.9	(4,856)	61.7	(1,702)
Percentage of sexually experienced young men 15-24 who had sex with more than one partner in the last 12 months. (NDHS '03 Table 10.10)	NA	NA	6.2	(1,702)
Percentage of sexually experienced young men 15-24 who used a condom at first intercourse. (NDHS '03 Table 11.11)	NA	NA	16.3	(594)
Percentage of young men age 15-24 who reported paying for sex in the last 12 months (Table 11.14)	NA	NA	1.8	(1,702)
Percentage of all men age 15-49 who reported paying for sex in the last 12 months (NDHS '03 Table 11.14)	NA	NA	1.9	(4,428)
Percentage of women and men age 15-49 who believe that if a husband has an STI his wife can refuse to have sex with him or propose that he use a condom (NDHS '03 Table 11.7)				
Refuse to have sex	94.7	(13,633)	94.1	(4,428)
Propose that husband use condom	NA	NA	78.7	(4,428)
Refuse sex or propose husband use condom.	NA	NA	97.3	(4,428)

Untapped Potential for 2003 NDHS Male Module

While much useful NDHS data for men are presented in the October 2004 NSO report, a large amount of important data remains unused. It is not a simple matter to use the data for male respondents, however. Many questions for men are either not comparable; or, if comparable, the questions are often asked in a different sequence or context in contrast

with the questions for women. For example, unlike women in the 2003 NDHS, the male module does not ask men about their current method of FP. Rather, men are asked about FP use at last intercourse, a very different way of eliciting information on contraceptive use that is likely to result in a very different profile than a question on current use. Despite these complexities, the following are examples of some of the promising variables that have either not been analyzed or the results of the analysis have simply not been published:

- Overall men's approval of FP;
- Men's reported condom use at last intercourse;
- Reasons for condom use at last intercourse;
- Use of other methods of contraception at last intercourse, if any;
- Reasons men give as to why a method was not used at last intercourse, including whether the wife objects to a method being used;
- Knowledge and attitudes toward condoms;
- Knowledge and attitudes toward vasectomy;
- Rates of marital infidelity,[2]
- Fertility preferences to permit comparison of the man's actual number of children versus his desired number of children; as well as a comparison of men's with women's fertility preferences;
- Men's attitudes toward the rights of women in decision making. This is important given how favorable men's attitudes seem to be on negotiation of safer sex as shown above.

FINDINGS AND CONCLUSIONS

Men, adult and young alike, have favorable knowledge and attitudes related to FP. Very few adult men, unlike a substantial number of young males, report the use of contraceptives. Adult men have a very high unmet need (for all methods) and young men have some unmet need for more reliable methods, such as the condom. Reasons for using and not using methods have been shown to be largely due to economic, familial and gender-related factors in their order of mention. Reasons pertaining to service provision, although cited as a contributing factor, have yet to be investigated for its facilitating and hindering roles in method use. Research has not been effectively utilized to broaden men's involvement in FP in the context of their own use of the methods or in supporting their female partners' use of the methods.

RECOMMENDATIONS

Short term and long term recommendations for research are presented below in the final Section VII.

[2] Data have been published on multiple partners for young men, but not for all married men.

IV. REVIEW OF CURRENT PROGRAM AND OPERATIONAL POLICIES AND GUIDELINES: HOW THEY ENHANCE OR DISCOURAGE MALE INVOLVEMENT IN FAMILY PLANNING

INTRODUCTION

Policies across sectors on national and sub-national levels offer numerous prospects for men's increased involvement in FP. This section details such opportunities, with a focus on policies whose implementation may encourage men's involvement. In cooperation with or independent of such supportive policy environments, policy strategies may also inhibit the positive involvement of men in FP. Such constraints are also described here.

This assessment revealed both informal and formal policy elements that facilitate and/or inhibit male involvement. Informal policies here refer to unwritten or casual protocols. Examples on the national level include high-ranking Filipino government officials' reluctance to support FP, thus, limiting potential opportunities for male involvement. More local informal policies are illustrated by a mayoral dictum in Valencia City, Bukidnon, declaring that PhilHealth benefits, including full reimbursement for nonscalpel vasectomy, are restricted to couples who bear only two or fewer children. Informal policies related to male involvement affect women as well. In Cebu City, a metropolitan FP clinic implements an unwritten service delivery protocol, unwritten but often implemented, whereby wives of NSV acceptors were encouraged to accept the injection of one dose of DMPA in order to eliminate the "uncertainty" of men's condom use in the period immediately following NSV.

The scope of relevant formal program and operational policies extends from national bills calling for equal inputs from men and women in FP, to military circulars emphasizing men's constructive roles in FP. Several salient elements from this continuum of policy opportunities are described below.

SELECTED POLICY ELEMENTS

National Government Initiatives

<u>Bills</u>

Numerous bills related to reproductive health and FP have been submitted for consideration by the Philippine House of Representatives and the Senate and currently await debate or further revision (Appendix E: Matrix of Population and Reproductive Health Bills). Notably, none explicitly champion men's involvement in FP, despite provisions on "couple" or "shared" responsibility in reproductive health (Philippine Legislators' Committee on Population and Development for the Reproductive Health Advocacy Network, 2004).

DOH

Men's RH Framework

The PNGOC convened a workshop on men's reproductive health in November 2002, producing a strategic program framework and a proposed Men and Reproductive Health Policy Statement (PNGOC, 2002). The statement was submitted to the DOH Center for Family and Environmental Health, but no administrative action has been taken to approve the statement.

The DOH reported to the assessment team that despite the absence of official action on men and reproductive health, links will be made to ensure male involvement is maximized in DOH FP protocols (DOH, 2005).

Given limited funds, the DOH intends to pursue men's support for their partners' use of FP, as well as the use of male methods (the "male involvement in RH" perspective), rather than pursuing activities related to men's infertility or STI-related needs (the "male RH" perspective). It is noteworthy that the DOH is mandated to retain five percent of the operating expenses of its hospitals for "health promotion", including voluntary sterilization. Technical assistance to the DOH in strategically using such funds is one way towards higher male method acceptance.

In addition, DOH's support to men and FP must also be made public. Often, the DOH's current silence is a limiting step for many programs. For example, the ReachOut Foundation reported during the team interview how the DOH had once provided free space on media channels for IEC campaigns. However, no such free support for media has been offered by the current administration. ReachOut has a media campaign ready for all FP methods, including special spots for condoms and vasectomy, but DOH's silence and their limited funding restricts the dissemination of innovative media strategies (Fleras, 2005). Similarly, the Philippines Advertising Board's discomfort with public FP messages in the media has restricted condom social marketing efforts when condoms are positioned as a pregnancy- prevention measure (Lapitan, 2005).

MCH Guidelines

The DOH's MCH Guidelines, approved as Administrative Order 79 in July 2000, "encourage partner as well as family and community involvement in pre-natal and post-natal services" (DOH, 2000). Revised guidelines developed with support of the Japan International Cooperation Agency are presently under consideration; these guidelines further support men's involvement in maternal and child health care and explicitly make links to FP opportunities during the prenatal period (Danila, 2005). Operations research has demonstrated how male involvement in their partners' prenatal care increased couples' discussion and use of contraception and improved knowledge about pregnancy and FP. In this regard, such links in the DOH guidelines are noteworthy (FRONTIERS Project, 2004).

Donors

USAID

The USAID Gender Plan of Action of 1996 states: "Through attention to gender issues, our development assistance programs will be more equitable, more effective and – ultimately – more sustainable" (USAID, 1996). The implementation of this vision is governed by Automated Directive System (ADS) requirements that mandate the consideration of gender concerns in the areas of strategic planning, activity planning and performance monitoring, competitive solicitations, and annual reports. USAID investments in opportunities to involve men in FP as part of a broader population, health, and nutrition strategy are supported by and relevant to these requirements.

Harmonized GAD Guidelines

In 2003, the Philippines' National Economic and Development Authority (NEDA) and the Official Development Assistance Gender and Development Network consolidated guidelines for the development, implementation, monitoring, and evaluation of programs making use of Gender and Development (GAD) funding (NEDA, 2003). With input from bilateral and multilateral agencies, these guidelines offer useful tools in analyzing programs at all stages for gender-related implications. Specific to reproductive health, the guidelines suggest that gender differences be noted in a program's design of "participation in reproductive health services and programs". Specific links to men's positive involvement in reproductive health and/or FP are not detailed.

PhilHealth

Accreditation

PhilHealth offers full reimbursement for NSV procedures performed in "accredited" facilities. An increase in the range of facilities that could be granted such accreditation is one opportunity to maximize PhilHealth's coverage. DOH licensing and PhilHealth accreditation are needed for remote infirmaries for out-patient family health services and minor surgery as "a step towards assuring equitable access to priority public health services and curative health care" (Flavier, 2005).

Accreditation requirements for NSV recently became less demanding due to the March 2005 DOH revision of licensing criteria under Administrative Order 183 series of 2004. Originally, one set of criteria was applied to all healthcare facilities wanting to provide ambulatory surgical services. Even for a relatively simple procedure like NSV, the facility was required to have an anesthesia machine, a defibrillator, operating room, etc. With the new criteria, the requirements depend on the service provided in that facility. While the requirements for BTL remain the same or more stringent, they are now more relaxed for NSV. A facility can now be licensed as an "NSV facility" with only an ordinary examination room and examining table, an NSV-trained general practitioner and NSV instruments. With these simplified requirements, it should be feasible to license (and eventually PhilHealth accredit) facilities in more remote and peripheral municipalities. Access to the service can be more equitably distributed rather than be concentrated in the bigger and more centrally located hospitals. The challenge to USAID

is to encourage meetings between NSV programs/providers and PhilHealth to develop procedures and guidelines that will expedite accreditation based on the less stringent DOH licensing requirements.

While accreditation is needed in more remote services sites, during the assessment team's interview, it was noted by Dr. Banzon of PhilHealth that providers should take full advantage of the more than 700 accredited facilities that can be used for NSV service delivery. Only a small portion of provincial hospitals currently provide NSV services. USAID CAs should be encouraged to introduce NSV in these existing accredited facilities.

Comparative Analysis of RH Morbidities

Dr. Banzon of PhilHealth cited the need for a comparative analysis of morbidity and mortality associated with FP as well reproductive health outcomes such as STIs (Banzon, 2005). Such an analysis could, for instance, profile the disability-adjusted life years saved by a PhilHealth policy that would mandate coverage for FP services beyond voluntary surgical sterilization. Comparing such benefits of FP to other priority health interventions such as tuberculosis treatment could further involve PhilHealth in maximizing choice in FP services and enhance prospects for men's involvement.

Other Policies

Pre-Marital Counseling

National pre-marital counseling, instituted by Presidential Decree 965, is required for a marriage license recognized by the civil registrar. The counseling sessions are ideally conducted by four facilitators from government agencies such as the Department of Social Welfare and Development, the DOH, the Population Office of the LGUs, and the Department of Agriculture (DOH, 1996).

With content sections including human sexuality, MCH, FP, HIV/AIDS, and responsible parenthood, the counseling sessions offer future married couples dedicated time to examine opportunities for male partner's involvement in FP. This may begin with elements of the counseling that ask couples to call into question the biological and social aspects of "What makes a man and a woman." Mutual consent and satisfaction in the sex act are prescribed, and FP is introduced as "a shared decision between husband and wife." However, opportunities for men's involvement are not explicitly highlighted.

Labor Policies

Under Article 134 of the Labor Code, companies employing 200 or more individuals are required to provide free FP services. This policy is an excellent example of providing an opportunity to reach men where they are, i.e., at the workplace. Program interventions to emphasize this requirement have been implemented by organizations such as the Trade Union Congress of the Philippines (TUCP) as part of collective bargaining agreements (CBAs) with great success. As of 2003, 68.8 percent of the 324 CBAs monitored by the Department of Labor and Employment included provisions on FP (Jaymalin, 2005). Measures must be implemented to ensure that men actually receive services covered

under the provisions of the Article, and ultimately, systematic evaluation of the impact of this policy and its utilization by programs could help clarify useful strategies for reaching men in the workforce.

Separate from Article 134, a national paternity leave policy allows seven days for fathers to care for their partners and children. Men availing themselves of such a policy could be approached along lines of communication that inform men about birth spacing and FP methods. In an interview by the team with former Secretary of Health Dr. Alberto Romualdez, he suggested a potential creative enhancement of the paternity leave policy, whereby men would only be allowed leave if they participated in their partner's antenatal care.

Military

A draft circular that will implement an FP program in the Department of National Defense (DND) and its bureaus, agencies, and offices is currently awaiting approval of the Chief of Staff of the Armed Forces of the Philippines. The policy declares that "population issues are inextricably related to the enhancement of national security because a rapid population growth rate impacts on the economic development and political stability of the country" (DND M.D.). The proposed FP program will include awareness-raising about FP methods among members of the defense establishment, training of service providers and counselors, and provision of FP commodities.

TSAP-FP, which is managed by AED, provided technical assistance in the drafting of this proposed policy. The accompanying series of fora with multiple stakeholders in the defense sector garnered support and interest in men's roles in FP. Notably, a platform of population's effects on national security was the focus of such fora, illustrating how support for male involvement in FP may emerge from a broader framework beyond the scope of FP itself.

Men as FP Promoters

Many policy leaders interviewed during this assessment reiterated the critical importance of having men serve as visible influentials for men's involvement in FP, both in terms of supporting women's voluntary use of FP as well as in championing men's acceptance of FP methods. Testimony by men on the benefits of men's positive and appropriate involvement in this concern can redress common myths about FP methods, and can challenge social norms about men's roles that exclude participation in FP.

KEY FINDINGS

1. Gender-related clauses in government policies across sectors offer a number of opportunities to specifically highlight the utility of men's involvement in family planning. A particularly strong move in this regard would come from the DOH's approval of the Men's RH Framework.

2. PhilHealth has shown support for NSV and is a key player in the continued efforts to increase access to the procedure in accredited facilities.

3. Innovative policies on male involvement in FP exist beyond the scope of the DOH, e.g., policies for men in the military and in the workforce.

Recommendations

Short-term and long-term recommendations for Policy and Guidelines are presented below in the final Section VII.

V. INFORMATION/EDUCATION/COMMUNICATION, BEHAVIOR CHANGE COMMUNICATION (IEC/BCC) AND SOCIAL MOBILIZATION STRATEGIES FOR MALE INVOLVEMENT IN FAMILY PLANNING

The objectives of this section are: 1) to briefly describe the themes of selected IEC/BCC/Social Mobilization materials to hasten the acceptance and utilization of FP methods by men and their partners; 2) to identify some IEC/BCC/Social Mobilization strategies utilized by selected agencies to facilitate the involvement of men and their partners in FP; 3) to identify issues generated by the foregoing IEC strategies; and 4) to recommend male and couple-friendly IEC/BCC/Social Mobilization strategies in FP.

IEC/BCC/SOCIAL MOBILIZATION MATERIALS: KEY THEMES

Around 40 materials, mainly about men and FP, were gathered by the assessment team during visits to selected public and private agencies in the country. Over half of these materials are posters/flyers, a few were training modules, books/monographs, comic books, and TV and radio ads (Appendix F). Majority of these materials were developed in Metro Manila. In Mindanao, the team noted that a vasectomy flyer, which was printed almost a decade ago, was being duplicated by some health facilities providing health services for men.

The key themes of these IEC/BCC/Social Mobilization tools are:

- Men's health (e.g., use of condoms to avoid diseases, description of NSV, proper use of condom);

- Men's responsibility for their own actions (e.g., a young man encouraging other men to know more about STD/AIDS and FP by visiting the health center);

- Men of all ages actively supporting their partners (e.g., a young couple who are both movie stars endorsing the SDM; the poster of Dr. Jondi Flavier testifying positive effects of NSV to himself, his children and wife; a TV ad of a young couple endorsing condoms; radio ads with male and female voices encouraging the public to use natural and modern FP methods). Most of the IEC materials fall under the third key theme.

Gender equitable tools of note are the training module for couples of the assets-based social mobilization program of Save the Children in Iloilo as well as the UNFPA training modules for RH (UNFPA, 2000). These materials utilize participatory approaches to training and men are in the equation at all times. Save the Children's module covers a discussion of human anatomy, the couple's perception of FP and different risk groups, population and environment links with FP, FP methods, testimony of a satisfied couple on FP, a couple's decision on an FP action card, and training evaluation.

IEC/BCC/SOCIAL MOBILIZATION STRATEGIES

Mass Mobilization of Men in the Workplace

One of the key strategies of TSAP-FP is reaching a large number of men through their respective institutions where they regularly gather as in the workplace. Funded by USAID since August 2002, TSAP-FP has engaged MRLs of the Autonomous Region of Muslim Mindanao (ARMM), the National Confederation of Tricycle Operators and Drivers Association of the Philippines (NACTODAP), and the National Defense College of the Philippines (NDCP) to facilitate the acceptance and use of FP methods among men and their partners in their respective locales.

In this strategy, TSAP-FP enjoins partnerships with influential male leaders of the above-mentioned institutions and provides information regarding population, development, poverty and related issues, health and FP situation and services, and modern FP methods. TSAP-FP programs solicit the program workers' own perspectives and plans to reach out to other men and their partners to increase the use of FP methods. Materials for effective communication are likewise provided to enhance advocacy skills to reach the target sectors.

With the MRLs, the TSAP-FP project cooperated in crafting a national fatwa intended to surmount hindering factors particularly the cultural belief that FP is not allowed in Islam and the widely-shared notion that FP is a strategy of the government and its allies to decimate the small Muslim population in the country. Those who disseminate the religious and health aspects of the fatwa are highly-respected male and female Muslim religious leaders and health service providers in the region. These influentials have also developed culturally-appropriate orientation materials (e.g., the marriage counseling guide for the ulama and the orientation guide for MRLs).

Interviews with selected Muslim male and female leaders pointed out the need for other complementing strategies to quickly gain the attention of Muslims in the ARMM which is comprised of several large provinces. They suggested the following:

- Development of stand-alone radio/TV messages oriented to Muslims conveying that FP is allowed in Islam and can enhance sexual relations with one's partner. These messages should also inform people where the services and commodities can be obtained;

- Development of posters or billboards showing Muslim influentials (with large photos) endorsing above messages and placed in and outside of health centers;

- Provision by the DOH to the health facilities of the needed FP commodities to meet the increased awareness about FP, including making quality services more readily accessible to potential acceptors.

- Assigning to health centers preferably male midwives/BHWs who could be more easily approached by men for FP services and commodities. If this is not possible, female midwives must be made sensitive to health needs of men. This was shared by Muslim women respondents, who are themselves health providers, who reported that

Muslim men tend to feel very squeamish whenever they would ask for condoms because they are mostly women. Some men reportedly ask for condoms after almost all women clients have left the center. They would ask to have their blood pressure taken and then discreetly ask for condoms. This raises the issue of how to make FP service protocols more sensitive and more friendly to men. This is further addressed in the recommendations section that follows.

- Conducting house-to-house information campaign by a team of health providers and MRLs (similar to "Ligtas Buntis" campaign) to better explain the religious aspects of the fatwa and the modern FP methods in response to the FP needs of the couple;

- Dissemination of the fatwa and information on FP methods in the workplaces where there are many Muslims especially in some factories in Iligan City;

- Requiring that all Muslims who are getting a marriage license receive an orientation about the fatwa and about FP. Males could be separated from females in some counseling sessions.

The NACTODAP has collaborated with TSAP-FP in engaging about 100 presidents of its local associations (numbering more than 2,000 all over the country) to become peer motivators in their respective associations. The five-day orientation training provided by TSAP-FP in February 2004 included the following topics: macro picture of the relationships between and among population, development, and poverty; the country's health situation; the health of tricycle operators and drivers; the various FP methods; and FP communication techniques. The peer motivators' messages emphasize that men make important contributions to FP; that they are partners in FP promotion by discussing it with others, by supporting their partners' use of a method, and by using FP methods themselves. The organization is getting positive feedback from the various peer motivators.

Marie Stopes developed a close collaboration with a tricycle operators' association near Manila through the MALE CALL program which was funded by the Turner Foundation. The project successfully promoted men and RH services for the association members and their families. The project became unsustainable financially, however, and was ultimately terminated. Among the lessons learned from the project was the concept of fathers developing closer relationships with their sons as an effective means of conveying RH messages. Marie Stopes has since initiated projects with male adolescents, including training youth leaders in local government councils to be peer educators for FP and HIV/ AIDS prevention. This appears to be a useful model for reaching young men (Marie Stopes, 2005).

The TUCP is a 30-year old organization which has since 1998 launched a program that targets men's health for the 22 out of the 35 million workers (as of January 2004) throughout the country. Supported in part by UNFPA, TUCP utilizes a comprehensive reproductive health approach to men and FP. Many men work in hazardous jobs and are often victims of accidents. Their "macho" psyche makes them vulnerable to occupation and RH hazards. Meanwhile, programs addressing their unique health needs are few (TUCP presentation, February 8, 2005).

To encourage men's participation in the program, TUCP developed posters that depict men as responsible partners of women. It has successfully negotiated with employers in its collective bargaining for a subsidy of P500 per month for each covered worker for the union's RH program. This amount is not limited to contraceptive pills, IUD, and Pap smear. In addition, service providers in 10 family welfare clinics serving union members are trained on gender-responsive planning and services and are updated in contraceptive technology and quality care.

An important IEC strategy used to increase knowledge and commitment to FP and RH among young men is the weekend seminars using a training module that focuses on shared and active involvement, gender sensitivity, FP methods, STI and other related health issues. The men are also informed about vasectomy as a permanent method and as an option for those who reached their fertility goals. The TUCP has also trained a network of male peer educators on FP/RH.

Despite positive feedback about the foregoing strategies and activities, the union noted a number of issues. It reported that men are "still tied to their time sheets and cannot devote their time to FP/RH activities even as they feel the need to." The union leaders felt that "given proper education and information, men will respond positively." The organization also needs the participation of opinion makers among union leaders to speak favorably about RH and FP, about prostate cancer and other health issues. It also sees the need for more IEC/BCC "activities to facilitate access to information and services and so that new gender images will break stereotyped sex roles."

Kidapawan City's MIU have been engaged in RH and FP promotion in their respective workplaces. The recent drafting of a circular institutionalizing FP in the armed service is a major development among this group. The group feels it is important for men in the service to learn about FP in order to dispel the common notion that FP is a female concern and that the use of an FP method would diminish their manhood. They recalled the orientation provided by the Provincial Health Officer (PHO), a male, because he was very straightforward in his language when he presented FP, RH, sexuality and men's relationship and responsibilities toward their partners. They felt that the clear explanation of the PHO helped them to be effective FP promoters in the barangays where they are stationed or they visit, and in their respective camps (FGD with MIU, February 14, 2005).

The MIU respondents see the need to address incorrect information about modern FP methods (e.g., they are considered abortifacients) that is being circulated by the Catholic Church. The MIU respondents also see the need for male providers at the health centers because many of the women health workers, currently in the centers, are insensitive to their FP needs. They reported that they are often heckled as "womanizers" by these health providers when they would ask for condoms.

Based on qualitative interviews and the FGD, the MIU participants suggested the following to facilitate the group members' and their wives/partners' use of FP:

- Communication activities:

    1. There should be more *pulong-pulong* (dialogue) on FP with *barangay tanod* (village peace and order officers), local leaders who are mostly men in the various barangays. Updated flyers in the local language could be provided because what they have are general information about FP methods which are obtained from the PHO.

    2. There should be posters with messages/slogans showing MIU as models who are introducing RH/FP to the barangay to portray that they are responsible men and to dispel the widely-shared notion that they are womanizers.

    3. The radio program such as the *Pulisya ng Katawhan* (Police of the People) should include a discussion on FP, e.g., policeman encouraging his partner/wife to use an FP method.

    4. TV program advertisements should portray MIU giving testimonies about FP.

- Health services with male health providers and BHWs and even a men's desk for FP similar to the women's desk for violence against women and children (VAWC) so they will not be embarrassed or heckled whenever they would ask for FP advice and condoms.

- An RH law so that various groups and institutions can receive scientific explanations about FP and population, poverty, and security issues can be addressed.

The MIU members preferred the use of NSV when they have reached their fertility goals because they learned from their training that BTL is a much more risky procedure than vasectomy.

Social Marketing/Mass Media

The DKT Philippines is a 15- year old NGO that has a two-pronged aim of improving public health "through pro-active social marketing interventions that enhance continued effective FP practices as well as contain the spread of STI and HIV/AIDS." It promotes a variety of condoms to varying social classes of sexually-active men and women between the ages of 18-35 and markets oral contraceptive pills and injectables to young couples between the ages of 18-30.

DKT strategies span the range of the gender integration continuum. In the late '90s, it had a series of TV advertisements of young couples endorsing condoms. In recent years, it had a flyer showing a popular radio announcer and his son and other wholesome-looking members of his family and friends to market condoms. In marketing the injectable, a photo shows the face of a happy woman with a smiling man behind her. A new TV ad shows a popular TV star with her partner and family in the background endorsing the pill. While the foregoing ads may be assessed as gender equitable, the commercial used to promote condoms for safer sex and FP are not as gender sensitive. For example, flyers, table posters, and packages of condoms have depicted homely-looking comedians alongside very attractive skimpy-dressed young women proclaiming

that they are responsible and reliable men. These macho images are reportedly appealing to men because what are portrayed seem "culturally appropriate." The 2005 calendar on Trust condoms shows young attractive calendar girls with scanty clothing. More gender-equitable IEC strategies could achieve condom sales goals and simultaneously challenge traditional norms of masculinity that may inhibit men's positive involvement in FP.

ReachOut Foundation International conducted a media campaign in 2004 to promote contraceptive use in the country with support from the Packard Foundation. In the past year, it aimed to air 24-hour radio public service ads in five dialects in at least 200 radio stations. The short ads developed for modern methods had male and female endorsers conveying messages depicting respect and encouragement between partners in the use of modern methods (ReachOut Foundation, January to September 2004). As mentioned above, due to DOH policy constraints, the program did not get free air-time for advertising FP methods other than NFP.

ReachOut reported that radio ads have reached a high rate of listenership. In the NCR and in Leyte province, the campaign has surpassed its target number of increased acceptors. It was not, however, clear from the report what specific male and female methods were used because the data were not disaggregated. It was not specified what the male audience had to say about the ads (ReachOut Foundation, January to September 2004).

Community-Based Strategies

A number of community-based efforts have utilized varying IEC strategies to engage men and women in the use of FP methods. With funds from the Packard Foundation, Save the Children implements a community-based program in Iloilo linking FP with other community concerns like environment, family health and child survival (Save the Children, 2003). Its key IEC strategy is social mobilization well before any attempt to introduce FP. At least six months of intense effort is made with the community on other development issues before FP is even discussed.

The assets-based social mobilization forms the basis for FP intervention with couple motivators. The couple approach uses one couple for every 30 households in the villages. "Go sitio" means that they avoid working with barangay health center (BHC) leaders, trying instead to work with marginalized population. Trusted local users motivate others. It was found that the male community-based development workers are just as effective as the female CBD workers. A marked increase in the number of FP acceptors was noted in the beneficiary communities in 2001-02 (Save the Children, 2003). Save the Children will soon pilot a similar assets-based social strategy with a focus on NSV in collaboration with LEAD. While staff intensive, this promises to be a very effective approach.

The IPOPCORM initiative is similar to the effort of Save the Children, i.e., it is concerned with RH and the environment using in-depth and long-term social mobilization approaches. The program is managed by the PATH Foundation Philippines, Inc. and covers 105 coastal barangays in 18 municipalities, spanning nine priority marine conservation areas. IPOPCORM's program works to simultaneously build local capacity for coastal resource management and improve reproductive health outcomes in these areas through expanding FP services and focusing on the prevention of AIDS and other STIs. The program has a strong men and FP approach, including training male

community outreach workers. The program is highly notable for its carefully designed methods for collection of baseline and follow-up data to assess key male respondent indicators, including reported condom use at last intercourse. Results from the follow-up survey will be available next year and should be an important resource to assess the role of men in FP. IPOPCORM has achieved a ten-fold increase in access to FP services in the area in which it works, establishing over 800 service points in the program's coastal communities (Population Reference Bureau, Nov 2004).

The use of the SDM was introduced in June 2001 by the Institute for Reproductive Health (IRH) to the Kaanib (farmers' cooperative) in Malaybalay, Bukidnon in June 2001. IRH adopted the strategy of working in partnership with the CHO particularly with the nurse in charge of FP by identifying through the CBMIS couples who were not users of any method or are using a calendar method with a menstrual cycle of 26 to 32 days. The strategy ensures acceptance of the SDM by bringing together the husband and wife so that the method could be carefully explained to them. A two-page flyer in Cebuano language was provided to couples including the necklace and a calendar.

Professor Sealza suggested the following strategies to promote SDM: 1) the experiences of successful couple users must be publicized and shared in various public gatherings such as the barangay summit and public hearings for bills and other matters; 2) messages through radio ads and drama would be another venue for successful users to dramatize their experiences; 3) the red SDM flyer with the photo of a popular action star and his wife with the necklace should be turned into billboards and placed in strategic locations in the province and other places. Having a wholesome popular couple makes it easier for the public to recall SDM information because of the penchant of Filipinos to believe the endorsements of movie stars.

The Male Involvement in RH project in Nueva Vizcaya (the province with a CPR of 67 percent, the highest in the country) was initiated by a municipal health officer (MHO) who sought the participation of elected local barangay officials as role models within UNFPA's RH program. The project, which started in 2003, identified the male groups and their political structure, in particular the barangay and its purok leaders where RH could be introduced. The target groups of this initiative are the husbands of married women and male adolescents. The project aimed to involve the men on various aspects addressed by the UNFPA comprehensive RH health training modules, including FP, gender and sexuality, STD/HIV/AIDS, male RH, adolescent RH, and violence against women (UNFPA 2000). Strategies were designed to raise the level of men's involvement and by organizing and training them as peer motivators and counselors, FP consumers, and as sources of FP support for their partners/wives. The MHO conducted a series of training for eight to 10 weeks regarding the 10 elements of RH over a period of three months with the use of the UNFPA training modules. The MHO reported that these training activities were so successful that attendance grew to include both men and their partners and older children. The participants became trainers themselves and they chose topics that they enjoyed to teach and they extended their training to other municipalities.

Members of the Men and RH Task Force who were interviewed said they are supportive of FP and some of their members have had NSV. Although the men have considerable training in RH and are sensitized to gender issues and are more likely to practice FP, it was noted that they had little or no data to demonstrate any impact on FP use. There may

be advantages for a comprehensive multi issue RH approach versus a narrow approach that engage men on just FP issues. The MHO, felt that the comprehensive approach appears to captivate men's interest rather than the narrow focus on FP because they are also interested in sex and STIs, MCH, VAWC, and adolescent reproductive health..

LESSONS FROM THE IEC/BCC AND SOCIAL MOBILIZATION STRATEGIES

Based on the above examples of IEC/BCC strategies, the following are promising approaches to encourage men to accept FP methods for themselves and for their partners:

- Orient men on FP methods jointly with their partners/wives because it tends to sustain method use when men and women are able to communicate with their partners effectively (e.g., SDM users);

- Have male peers and superiors promote FP in the workplace and in their communities (e.g., TUCP, NACTODAP, Save the Children);

- Provide orientation training to male health providers and respected leaders (e.g., MRLs, MIU).

- Engage couple motivators to provide FP orientation to prospective male acceptors and their partners (e.g., Save the Children, assets-based social mobilization, SDM);

- Design media promotion materials (e.g., posters, flyers, billboards, radio and TV programs) to include subjects from their own ethnic communities (MRLs) or occupational grouping (MIU), or admired movie stars (SDM) and respected influentials (Dr. Jondi Flavier and NSV);

- Integrate FP into the clients' basic concerns in life such as environment and livelihood (e.g., Save the Children);

- Train health providers, both males and females, to be more sensitive to men's FP and other health needs; (e.g., TUCP, MIU, MRLs);

- Design IEC/BCC to address deep-seated cultural beliefs and biases (e.g., MRLs and the fatwa);

- Associate FP with larger issues that affect the country and the particular group of clients (e.g., TSAP strategies to involve influentials and their members).

Recommendations

Short term and long term recommendations for IEC/BCC and Social Mobilization are presented below in the final Section VII.

VI. ASSESSMENT OF FAMILY PLANNING PROJECTS AND ACTIVITIES THAT ATTEMPT TO CONSIDER MEN

The following observations came out from discussions with service providers and stakeholders as well as activities of NSV clients (14 clients and seven of their partners from four different areas) and SDM practitioners (four couples and two women who were SDM trainers) over the period February 7 to 17, 2005.

MEN AND FAMILY PLANNING: OVERALL PROGRAM ISSUES

In the Philippines, the low level of FP use is most prominent among poor households, those staying in peripheral and rural areas, and among older couples who are still fertile and sexually active. This is a challenge to the government or public sector that accounts for the provision of more than two-thirds of FP services (NDHS, 2003). The rest of the contraceptive supplies and services are provided by the private sector, both non-profit and profit-making organizations (Figure 1, Appendix I). The private sector tends to cater to the higher economic classes, and those staying in central or urban areas. In the country, the involvement of men as FP acceptors has been modest. Condom use is low. Over the last 30 years, on average, voluntary surgical contraception (VSC) procedures done on women were 15 times greater than those for men. (Figure 2, Appendix I).

For men at different life stages, there are characteristics that lead to different FP service needs (USAID Presentation Session, 2005):

- Adolescents need information and services, including education on fertility awareness and delaying first sexual activity, and advice on the proper use of condoms and other modern contraceptives.

- Men at the prime of reproductive ages need information on their role in facilitating their wives' or partners' practice of FP, promoting the value of condoms and NFP/SDM in married life, and consideration of NSV or BTL when they have completed their family size.

- Older persons may need to use NSV and other longer-term FP methods to limit family size.

Strategies to Reach Men

The main challenge to encourage male involvement in FP is to get them into action, directly involved in service delivery. This requires effective ways to reach out to men, in their homes, in their communities or in their workplace. The assessment team reviewed documents on a variety of approaches to reach men that can be classified into four categories: 1) CBMIS at the local health unit level as illustrated by Bago City and Bukidnon Province; 2) social acceptance mobilization approaches that endorse a gender equitable model of men and FP (TSAP-FP cooperation with the MIU, the tricycle operators and drivers, and MRLs); 3) comprehensive men and RH approaches that endorse UNFPA's Men and RH model (Davao del Norte and Nueva Vizcaya and TUCP); and 4) assets-based community mobilization that encompasses environmental

sustainability (Save the Children/PATH Foundation). All of these approaches are viable and the best aspects of each model should be shared to enhance efforts in reaching men. In this section only the first three approaches are further discussed from the perspective of access to services.

Community Based Management Information Systems

CBMIS is a process developed by the Management Sciences for Health (2003). It is carried out quarterly by BHWs under the guidance of the local health department staff. This monitoring system is multi-purpose by design, having applications for infant and childhood immunization coverage, tetanus toxoid at birth, vitamin A supplementation, and FP.

CBMIS requires that adequate local health staff at the barangay level should maintain accurate records for all households on a quarterly basis. Because the system is multi-purpose, many stakeholders are willing to invest in maintaining the system. For FP, CBMIS identifies married women of reproductive age with unmet need under the following categories: those not using any FP method; those who want to use temporary FP methods, and those who specifically want a permanent method (either NSV or BTL). It also identifies women who are using an FP method but are not satisfied with it (Figure 4, Appendix I).

In Malaybalay, Bukidnon, in June 2001, IRH worked in partnership with the city health office (CHO) particularly with the nurse in charge of FP by identifying through the CBMIS couples who were not users of any method or are using a calendar method. These are couples with menstrual cycles of 26 to 32 days. The nurse was able to promote the acceptance of SDM by working together with husbands and wives.

In Davao del Norte, in Bago City, and in some areas in Luzon (MSH, 2005), the rural health midwives assisted by BHWs use the CBMIS to identify and recruit acceptors with unmet need for both temporary and permanent FP services. For example, in December 2004 the Bago CHO CBMIS identified 279 married women of reproductive ages (MWRAs) who were not using FP and but who were interested in a temporary method, 80 MWRAs who were interested in BTL, and eight who were interested in NSV. Notably, the system identified 386 MWRAs who are not satisfied with their current FP method. All of these women are referred to the health center for counseling. These management data permit a careful follow-up of priority clients. While the CBMIS system normally focuses on women, more attention to men can result in acceptance of male methods and provide reassurance to men that female methods are safe for their partners.

With CBMIS, FP service providers can identify those who are not satisfied with their current method or who want a permanent method earlier. In areas with quality NSV services, CBMIS has important implications for providing access to NSV. Rather than work with an entire community, community health workers can attend to those with unmet need or who are not satisfied with their method. Using this approach, the MSH has reported that NSV services have increased from 20 a year in 2001 to 200 a year in 2002, and lately they are providing over 2000 men with NSV services annually (USAID and MSH 2003). For these men, NSV no longer needs to be a last resort but an early option.

Social Acceptance Mobilization

In contrast to the CBMIS approach, the AED through the TSAP-FP project works with around 40 champions and 100 community influentials, directing efforts at large organizations that are predominantly male, such as tricycle operators and drivers associations, and the MIU. TSAP-FP's cooperation with MRLs has also worked effectively among the group's senior male leadership. While the TSAP-FP program is not accountable to USAID for increased FP method use (its chief indicators include favorable attitudes toward FP), it does have an explicit male involvement strategy that emphasizes husbands' acceptance of FP and support to partner's use of FP that is guided by gender equity principles (TSAP-FP, 2005).

TSAP-FP programs that work with tricycle drivers and MIU are in the preliminary stage of the campaign and need to focus primarily on FP social mobilization before they can begin initiatives on counseling for FP. Nonetheless, these programs have great potential to reach men with concrete FP services in the future. Because of TSAP-FP's effective work with the Philippine military, a military memorandum, soon to be formally approved, will require the provision of FP services.

TSAP-FP's cooperation with NACTODAP has made impressive progress to train TODA leadership and eventually may develop formal linkages to FP services. However, too much emphasis in the early stages on concrete FP services could be counter-productive as the ground work must first be made with effective communication program at various levels. While this essential initial work is being done, it is hoped that the TSAP-FP will begin planning for programs to ultimately provide access to service delivery for those people who are persuaded by their FP champions. With the improvement of FP awareness among men, there are opportunities for bringing the services to where the men are: in military camps, in workplaces, and in transportation terminals, among other examples. There are prospects for ensuring that together with FP mobilization and social acceptance programs, accessible sources of FP services will be identified and condoms, NFP-SDM and NSV will be made available by national and local government agencies, and by private sector groups (USAID Presentation Session, 2005).

Comprehensive Men and RH Approaches

TUCP

The UNFPA-assisted TUCP program endorses a comprehensive RH approach. It addresses FP as part of a wide range of issues, such as VAWC. The projects seek to reduce the cost for men wanting to practice FP by bringing services to where they live or where they are employed. This is illustrated by the approach taken by TUCP which has succeeded in getting FP services in the workplace (TUCP Presentation, February 8, 2005). Similar attempts targeted at working men, their wives or partners are carried out by the Department of Labor and Employment (DOLE), and FP and MCH Association of Philippine Industries (FPMCHAPI).

TUCP, which has national coverage, provides several broad RH services to adolescents and most working-age men. As noted above in the section on policy, TUCP has made impressive use of CBAs to get support for FP services for its workers. However, for male

methods of FP, the acceptance was quite low. In fact, there was only one NSV done over the three-year reporting period (Figure 5, Appendix I). But this in no way diminishes the value of marketing and mobilization efforts carried out by these organizations. To increase the use of male methods the next step is to move towards linking broader reproductive health campaigns to specific FP service delivery, and connect IEC and social acceptance campaigns to NSV services of the LGUs and the private sector providers for TUCP members.

Nueva Vizcaya

As shown in the foregoing section on IEC/BCC, Nueva Vizcaya has a comprehensive male RH project ongoing in about half of the province's municipalities. Using provincial health office data, FP performance was compared between the areas with and without male reproductive health committees. While somewhat higher for new acceptors of condoms, overall FP performance has not increased markedly in areas with MRH Task Forces. For a high CPR province in a high CPR region, FP may not have been prioritized because it was already high to begin with (Figure 6, Appendix I).

Davao de Norte

This province is outstanding in its commitment to men and RH. Here, condom use at seven percent is three times the national average. This is reported to be the result of the male FP and reproductive health programs of the province which is driven by a formal policy enforced by Provincial Ordinance 2000-003: "An Ordinance Creating a Male Reproductive Health (MRH) Clinic in All Rural Health Centers in the Province of Davao del Norte." This is also evident in the strong expression support to male FP among the municipal mayors and MHOs in Davao del Norte (Table 8 and Figure 9, Appendix I).

Outreach NSV Services and NSV Services in Static Healthcare Facilities

Valencia City

In Banlag, a barangay in Valencia City, Bukidnon (Figure 7, Appendix I) which generated the most number of NSV clients, the first two acceptors of the method were men who are known in the community – an educator and the son of a Datu. These men gave testimonies and motivated other men in their village to accept NSV (Naypa, 2005). It was not only the message, but also the messenger that became important. Health care service providers and the wives of men of influence are good messengers. It was observed that there are motivated and charismatic physicians who have successfully recruited NSV clients (USAID Presentation Session, 2005). Women during their pregnancies can effectively provide their husbands or partners with information. In cases where men want to be present during the delivery of their wives, they become aware of the difficulty of childbirth became motivated to practice FP and even accept NSV (Contreras V, 2004).

Religious Groups

Like the Catholic Church leadership, religious leaders and other faith-based groups differ in their opinions and interpretation of the fatwa on FP by ulamas in Basilan (who do not

allow NSV). This is in contrast to the ulamas in Maguindanao (who allow NSV). While other faith-based groups may facilitate FP access by men, others may also constrain the involvement of males in FP. FP service providers also reported that among family members, friends, and neighbors there are those who also oppose male FP.

Dujali, Davao del Norte

A variety of approaches have been used to encourage NSV among men. It was repeatedly found that men opted for NSV due to financial difficulties in supporting additional children. For many men it was important that NSV is provided free or at little cost.

Last year in Dujali, Davao del Norte, two NSV campaigns were conducted. Thirteen NSVs were performed in September 2004 and 23 in November 2004. Some NSV clients were provided with transportation allowances and other means to offset lost wages. NSV clients who are daily wage earners do not have resources to cover lost income. In this context, transport payments and food allowances can be considered reasonable compensation for lost wages and are not incentives that tend to coerce.

In most of the FP service facilities that the team visited in selected areas of Luzon, Visayas, and Mindanao, males are first motivated and exposed to satisfied FP acceptors and then counseled on NSV. Before and after surgery, informed consent for FP is sought. After surgery, post-operative instructions are given to the clients in the local dialect.

NSV service providers are readily available in some provinces. There are currently six NSV surgeons in Davao del Norte, one from a referral hospital, and the rest from the LGU health centers.

Monkayo, Compostela Valley

Since most of the NSV services are provided during one-day campaigns, NSV surgeons work closely together during such campaigns when as many as 20 to 150 male clients come. Such enthusiasm for NSV provision can be seen in Monkayo, Compostela Valley where over 100 NSV procedures a year have been done for the last two years by the MHO staff.

Bago City, Negros Occidental

This is the same in Bago City, Negros Occidental where over 300 NSV procedures have been done by the CHO staff in the last five years (Figure 10, Appendix I). In these municipal or city health offices, the physicians are not heavily involved in FP service delivery. Thus, their provision of NSV services for men will not disadvantage women acceptors.

Cebu

In the private and public hospitals visited in Cebu, the Regional DOH FP officer reports that specialists in these higher-level health facilities are less interested in doing NSVs, which are considered to be simple out-patient procedures (Baking, 2005). Even if most of these hospitals are PhilHealth accredited, their physicians would prefer to perform

procedures with higher reimbursement value. Most obstetrician-gynecologists would prefer Caesarian sections instead of BTLs. And among urologists or general surgeons, the removal of an inflamed appendix or hernia repair may be more attractive than NSV.

Private Practitioners

In the private sector, some members of the Philippine Academy of Family Physicians contend that with average consultation fees of P150 to P200, members could be attracted to the P600 professional fee prescribed by PhilHealth for NSV. In Valencia City, Bukidnon, it is primarily the commitment to NSV service that drives the private clinic physician and the P500 per NSV that the city health office provides is a big bonus. Likewise, in neighboring Malaybalay City, the P5000 that is prescribed for working on sets of 10 cases is an attractive fee. However, for most surgical specialists, it is difficult for NSV service fees to match even a single surgical procedure where surgeons can charge P15,000 or more.

Primary health care and family physicians could be encouraged to provide regular NSV services in their clinics. For the specialists and higher-level hospital physicians, attending to walk-in NSV patients is not appealing to them in their regular service base. It may be best for NSV surgeons from this group to be occasionally brought to outreach settings where 10 to 100 procedures await their expertise.

Assuring Quality of NSV Services

Quality patient services include counseling for free and informed choice. Toward this end, MHOs in the different municipalities of Compostela Valley were given training manuals and NSV kits under the MSH LEAD for Health project. Like NSV teams being developed in other areas, NSV surgical competence and confidence in the province is built-up, the capacity to identify unmet need and motivate couples towards NSV is developed, and the support staff and other resources are established. NSV teams are organized around an "anchor" NSV surgeon with most experience to assure quality of care and provide back-up for any complication that may arise from an NSV procedure.

In Davao del Norte, a pregnancy occurred after an NSV of the male partner. It was believed to be due to a vas deferens that was left intact, but was corrected afterwards by the "anchor surgeon" of the group. This "anchor" system helps the FP program by building up the confidence and competence of less experienced NSV surgeons.

In Valencia City, Dr. Isamael Naypa, the private NSV service provider, is a surgeon with more experience so he assumes the role of "anchor" NSV surgeon. He trains other MHOs and general practitioners to do NSV, and they consult him regarding complications or related concerns. Senior "anchor" NSV surgeons carry out peer training sessions for physicians who want to learn vasectomy techniques. Other members of the NSV team are also trained to inform and motivate clients, provide FP counseling, and maintain quality clinical care.

While identification, orientation, and counseling of NSV clients are done by the CHO in Valencia City, the actual surgery is performed by Dr. Naypa, a private physician. This physician provides services to the CHO at least once a week and is usually on call

whenever an NSV client comes. Services may be improved with this and other examples of complementary arrangements of the public and private sector, and cooperation and referral links among FP service providers.

NSV services in many public health centers are unable to provide complete privacy. This is due to some setups where counseling sessions may be overheard by other patients or there are not enough screens to protect the patients from the public. In most cases, there are just too many people in the health facilities like health personnel who want to observe and learn the NSV procedure and other patients milling around and waiting to be served.

In general, most of the patients in the CHO of Valencia do not mind a less private setting. However, most of the private or paying NSV clients do not even want other medical assistants to be around when they are operated on. During discussions with the NSV clients in Monkayo in Compostela Valley, in Bago City in Negros Occidental, and in Nueva Vizcaya (2005), the need for privacy and other concerns in NSV services were outweighed by the desire of the men to have NSV due to economic, household health, and FP reasons.

Furthermore, it was noted that almost all the NSV clients interviewed did not mind the fact that the health service personnel were usually females. Motivators, educators and counselors were mostly women. Around a third of NSV surgeons are female. Thus, it is important to develop the capacity of healthcare providers to deal with men or with couples and not with women only. Health care providers, particularly those who see FP as purely a woman's domain should be given a gender perspective reorientation. As a service given mainly to women, FP may be an additional burden imposed more often on women and not equally on men.

With the incentive of reimbursements, FP service providers are encouraged to maintain standards of quality and accreditation that are set by PhilHealth and guided by the licensing criteria prescribed by the DOH. But the quality of motivation varies with the level of the facility as in the case of primary level facilities which are more positioned to perform NSVs.

Financing FP Services

FP practice of men is shaped in part by the inherent cost of accepting the FP method including: the costs of purchasing the contraceptive or service; costs of acquiring information; costs of travel and time; costs associated with side effects; the variety-constraint cost of not getting the preferred method; and the psychological cost of using a method that may be accompanied by social disapproval (Gaverick, 2004).

For reversible methods of FP, there are important financial and non-financial costs for men. The FGDs found little evidence that financial cost was a limiting factor for condom use. As documented in the previous section on discussions with MIU in Kidapawan City, Sultan Kudarat, there are important non-monitory costs for men in the use of condoms, namely the embarrassment and risk of ridicule when asking for condoms from female health providers. Male partners of SDM couples demonstrate a strong commitment by making significant non-monetory investment in their effort to avoid sex at the fertile period of the female partner.

Costs for SDM can be reduced for couples by bringing SDM trainers to their neighborhood. Similarly the costs for men who want NSV may also be brought down when we bring services to where they are. During NSV campaign days, NSV surgeons may be brought to health centers or underserved areas to provide outreach services. While NSVs can be done in midwife clinics, these NSVs and BTLs have been referred out to physicians as far as one hour away and at significant expense for the client (WFMC, 2005). Apart from the travel cost, the time lost from work is a constraint for most men.

The transportation and actual cost of NSV services may be subsidized, as in the case of Dujali, Davao del Norte. This includes around P400 for supplies/medicines. In Valencia City, the local government also provides funds for the supplies and salaries for most of the NSV service team. The NSV surgeon is given around P500 for each surgery.

Most of the NSV services provided have been free or subsidized. Grants and assistance come from USAID cooperating agencies like the MSH and from UNFPA supported agencies that have provided support such as NSV instruments to LGU health offices and to NSV surgeons. For FriendlyCare, funding for VSC and NSV comes mainly from corporate sponsors. Even private individuals support NSV like the US-based surgeons who formed the No-Scalpel Vasectomy, Inc. that occasionally provides highly subsidized services together with the Sacred Heart Hospital of the Southwestern University in Cebu City.

But what will happen when subsidized NSV and free condoms are no longer available? In the case of the market for condoms (DKT, 2005), there did not seem to be any shift from clients relying on condoms from the DOH (Figure 11, Appendix I). As the volume of donated condoms declines, unmet need may have increased among those who get supplies from DOH. For free NSV, which has been an important motivator for men, it is likely that access to the procedure would decrease when the broadly free services contract. FriendlyCare faces a phase-out of USAID support for its operations and is considering ways to increase revenue through expanding the services it provides. One option is for FriendlyCare to follow the successful approach taken by Profamilia/Colombia whereby their large urban FP clinics became financially sustainable by developing high quality urology services for affluent middle age men who often have chronic prostate care needs (AVSC, 1997c). USAID should consider funding FriendlyCare to undertake a feasibility study to assess the feasibility of this strategy in the Philippines.

A large fund that has not yet been fully utilized for male FP services is from PhilHealth. The services observed are often conducted in district hospitals or facilities that are PhilHealth accredited. According to the PhilHealth, there are more than 700 facilities that have been accredited to provide NSV for members (Banzon, 2005). These healthcare providers may be reimbursed for P3,000 or even more for NSV.

While PhilHealth reimbursement for NSV has been available for most hospitals for a long time, primary healthcare facilities, like midwife clinics which refer cases or LGU health centers that perform more of the NSVs, find it difficult to access this fund (USAID Presentation Session, 2005). In many cases these types of facilities, unlike the bigger

hospitals, cannot be licensed by the DOH and therefore cannot be accredited by the PhilHealth because they cannot comply with requirements. Until recently, to get a license to perform NSV, the DOH required that the healthcare facility must have an anesthesia machine, defibrillators, and other operating room equipment that are too expensive and not even necessary to assure the quality and outcomes of simple vasectomy procedures.

From the PhilHealth side, when an NSV is performed in an accredited facility by an accredited service provider costs and procedures are itemized and only the allowed expenditures are reimbursed. It would be much easier if PhilHealth could instead reimburse a fixed amount for straight forward procedures like NSV. Simplified requirements and processes would make it easier to get financing and, thus, encourage more NSV services.

The primary source of income for some clinics like the WellFamily Midwife Clinics or the FriendlyCare Clinics is from deliveries and other MCH services. FP services are also provided but in terms of profitability, these services generate less income for these healthcare providers. For most FP services, midwives are more cost-effective service providers than physicians, except for VSC (FriendlyCare, 2005). While condom sales volumes may recover the cost for some organizations like the FPOP and DKT, for most FP service providers, NSV has the biggest profit margin. But NSV, like condom use, must be accompanied by demand generation like marketing and IEC campaigns.

Finally, FP is not a priority of the current national government. Male involvement in FP is not a priority of most NGOs and LGUs (DOH and PNGOC, 2005). As such, there are rarely enough funds to cover the cost of NSV promotion and service delivery. Most of the individuals and organizations met during the assessment feel that with improvement in policy and support for FP there would be higher acceptance of NSV and other FP methods by Filipino men and couples.

Findings and Conclusions for Service Delivery

FP services need to be tailored to meet the needs of men at different life stages. Male adolescents need information and services including education on fertility awareness and on delaying first sexual activity. These range from advice on improving the practice of withdrawal or use of less reliable FP methods towards acceptance of NFP or SDM, to proper use of condoms and other contraceptive commodities and procedures. Men at prime reproductive ages need information on their role in facilitating their wife's or partner's practice of FP. They need information and services promoting the value of condoms and NFP in married life and the consideration of NSV when they have completed their family size. Older men may need to use NSV and other longer-term FP methods to limit family size.

A wide range of promising approaches were identified for providing FP services for men and/or helping men to be more supportive of women using FP. These practices fall under three main categories: 1) CBMIS at the local health unit level as illustrated in Bago City and Bukidnon; 2) social acceptance mobilization approaches that endorse a gender equitable model of men and FP (TSAP-FP's cooperation with MIU, TODAs and MRLs); and 3) comprehensive men and RH approaches that endorse the UNFPA Men and RH

model (Davao del Norte and Nueva Vizcaya and TUCP). The best aspects of these approaches should be shared for comparative advantage.

While it is acknowledged that the involvement of men in FP entails more than the use of male methods, the assessment devoted considerable attention to the status of NSV services and couple perceptions regarding NSV. Promising strategies have emerged to systematically expand outreach to men for NSV services. These strategies should be encouraged in the context of informed choice and high quality care. The review of NSV services found CBMIS to be effective in identifying unmet need to reach and recruit men. It also confirmed the importance of assuring quality of FP services, especially for NSV. It identified the need to expand mechanisms for financing male FP Services and commodities.

With IEC/BCC and social mobilization, there must be a comprehensive service delivery approach toward four key groups:

- Young men supportive of and directly involved in FP;
- Adult men supportive of and directly involved in FP;
- Women supportive of involving men in FP;
- Health providers supportive of involving men in FP.

Health providers who see FP as a woman's domain should be given training for re-orientation of their gender perspective and for proper approaches. In this regard, service provision of FP services for men must be assessed and reoriented as needed.

Recommendations

Short-term and long-term recommendations for service delivery are presented below in the final Section VII.

VII. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS TO STRENGTHEN MALE PARTICIPATION IN FAMILY PLANNING

OVERALL FINDINGS AND CONCLUSIONS

This assessment has identified promising programs for advancing men's involvement in FP throughout the country, a foundation for future work that should be supported.

Cultural, behavioral and demographic factors in the Philippines are favorable to efforts to involve men in FP. Data on men's sexual behavior show positive trends: a relatively mature age of first intercourse (18.8) with the vast majority reporting they have been faithful to their partner and have not resorted to commercial sex workers in the past year. Data for young men show substantial FP knowledge and use compared to older married men. There is an opportunity to work with young men to encourage continued responsible sexual behavior. Attitudinal variables about men as reported by women, as well as the limited results published for men, suggest that the vast majority of men hold supportive views on family size, FP, and negotiation of condom use within marriage to protect a woman from a husband with an STI.

Other favorable factors include the high literacy rate in the Philippines and increasing labor force participation for women (not to mention that the country has a highly favorable social climate for, and a critical mass of organizations active in undertaking social development innovations).

The current status of MCH service delivery in the Philippines, with majority of women reporting four or more antenatal visits as well as at least one postnatal visit, may be favorable to replicating a strategy of including men in maternity, as currently being implemented in India on the basis of Population Council Frontiers OR Research (Frontiers, 2004; NSO ORC Macro, 2004). Given the need to reduce the delay between completion of desired family size and use of permanent methods in the Philippines, working to include men in antenatal and postnatal care, especially for their second and third child, may help to both improve birth outcomes and increase acceptance of effective FP methods.

There are positive factors in the Philippines, but unfavorable conditions restrict efforts to involve men in FP. Important constraints include: the adverse policy climate toward many methods of FP; the extremely low level of use of male methods, combined with the relatively low efficacy and continuation rates of these methods; the high levels of concern about side effects; and the current decrease in donor support for FP commodities.

The potential to expand the use of male methods must be realized. While the recent innovations in providing NSV are promising and warrant expanded donor support, the process of expanding access while maintaining quality care is a major challenge that may take many years. Women as well as men must be convinced that the advantages of NSV outweigh any potential adverse effects. Only a small percentage of women not using FP express interest in condoms in the future; even fewer women express interest in NSV. As part of the life cycle approach to fertility management, the condom seems to be a bridging method for couples who often switch to other methods. The real benefits from

involving men in FP will probably be found in increased acceptance, continuation and efficacy of female methods.

It is vital that future efforts to involve men adhere to a gender equitable framework. This will not only lead to good project design, but will reassure women's health advocates that their interests will not be jeopardized. While it may take some time before a comprehensive men and RH framework is adopted by the DOH, at the provincial level the UNFPA supported framework will no doubt continue to guide work to involve men. The important caveats of "constructive" involvement and working toward a gender transformative approach need to be kept in mind for any projects that are supported in the future.

For many if not most of the men interviewed, economic necessity appears to be the force behind their interest in FP. While men are seeking FP services out of urgent concern for how to provide for additional children, FP is largely promoted for its health benefits for women and children. Some NGO representatives feel that donor agencies are putting too much emphasis on the health benefits of FP and not enough on the self-interest of men as providers for the family. The promotion of gender equity and the health benefits of FP is absolutely essential, but it may not be the most effective entry point to encouraging men to be involved in FP. Serous lost opportunities to involve men in FP will result if programs fail to stress economic issues.

Overall, when working to involve men, there should be a comprehensive approach toward four key groups: 1) young men supportive of and directly involved in FP; 2) adult men supportive of and directly involved in FP; 3) women supportive of involving men in FP; and 4) health providers supportive of involving men in FP.

RESEARCH RECOMMENDATIONS

- Rationalize the men and FP research agenda, and strengthen and evaluate the use of research findings in programs and projects by supporting the creation and operation of an RTG to spearhead a systematic identification, definition and justification of research priorities. In order to accomplish this, it is recommended that USAID convene a small group (8-10 members) of researchers and FP program managers, to be called an RTG, for a seminar/workshop and follow-up work. During the seminar, participants would then be organized into 2-3 groups. Each group will be asked to respond to the question by identifying specific areas in IEC and service delivery in FP requiring systematic research. Group discussion results shall be summarized, and the top five priority research areas shall be determined by voting. After the seminar/workshop, the RTG would guide the implementation of commissioned studies on these areas to make sure that the research questions needing evidence are addressed, and that the appropriate respondents are interviewed. The RTG would also ensure that the results of the studies will be effectively used in programs/projects. On the whole, RTG will be a research advisory group.

- Invest field support funds into the MEASURE/DHS project for an in-depth secondary analysis of existing data on men and FP with special emphasis on the results from NDHS 2003 Male Module. While secondary data on men and FP such as those of the NDHS 2003 are available, these have yet to be thoroughly analyzed to provide

additional information on men's perspectives and experiences on FP-related matters. USAID/Philippines should invest field support funds into the MEASURE/DHS project to analyze available data on men and FP within four months.

- Implement short term high priority research and OR studies. USAID/Philippines can capitalize on centrally-funded research mechanisms such as the FRONTIERS project and the Contraceptive Research and Technology Utilization (CRTU) project, in order to implement operations research that addresses pressing questions about men and FP. Three examples of recommended areas of research are as follows:

  1. Explore mechanisms for changing men's FP behavior. Support studies that will document behavior shift (for example, from not using to using a method, or from using an unreliable to using a reliable method) and the explanations to such a shift.

  2. Explore how service provision in FP is facilitating or hindering men's involvement. Support operations research to diagnose, test and evaluate the role of service provision in facilitating or hindering men's use of FP method or men's supporting their partner's method use.

  3. Evaluate the impact of IEC on the FP method use among men and their partners.

  Other short-term and long-term priority studies would be determined by the RTG.

POLICY AND GUIDELINES

Short-Term Recommendations

- Designate and fund a USAID CA or qualified local agency with policy experience to systematically support relevant policy guidance initiatives, which include: the Men and RH Framework; policies in labor, education, military and the newly developed DOH MCH Guidelines, all of which may serve as effective platforms for men and FP. This agency would be responsible for monitoring and evaluating a wide range of national, regional and local government policies from the perspective of men and FP. UNFPA has successfully collaborated with PNGOC on the development of a men and RH framework and POPCOM emphasized its interest in these types of activities.

- Fund a USAID CA or qualified local agency to organize a Policy Analysis Forum to build on previous efforts of PNGOC and bring together stakeholders from public and private sectors to discuss opportunities and constraints for male involvement in FP within policy guidelines and protocols. Similar fora implemented in Cambodia and Mali by the POLICY Project have convened donors and government partners to analyze key policies related to FP, birth spacing, and HIV/AIDS. Such analyses have resulted in a clear matrix of policy recommendations identifying both prospects and gaps for male involvement. Examples of such prospects would include monitoring and evaluation of policies such as labor policies requiring FP service provision and GAD funding policies. Tools and background information for these activities are available from the POLICY Project and the IGWG and could be adapted for use in

the Philippines, where the LEAD for Health Project would be a key partner in such a forum given the project's policy-level mandates on FP.

- Organize NSV service providers as a group to work with the DOH to streamline requirements and procedures for accrediting NSV service providers, NSV facilities, and even clinical practice guidelines or protocols. A group of organized NSV providers should seek formal recognition by the DOH and possibly the Professional Regulation Commission or Civil Service Commission as the official body to certify that a physician is properly trained to perform NSV. This is similar to the Obstetrician-Gynecologist Society or the Ophthalmologists' Society certifying that their resident physicians are qualified specialists in their field. USAID CAs with expertise in NSV should be called on to help NSV service providers develop an organization and support their efforts to seek recognition from an appropriate Commission. Support from the LEAD for Health Project and the Private Sector Mobilization for Family Planning Project (PRISM) could link NSV providers as a medical board that can institute certification and accreditation protocols. This could increase the availability of PhilHealth-accredited facilities that can perform voluntary surgical sterilization, including NSV.

- Create guidelines for male policy leaders in support of men and FP. As part of its efforts to increase FP acceptance, the USAID CAs, such as AED through the TSAP-FP project could mobilize male policy leaders in its IEC and BCC activities in order to enhance men's involvement in FP. To expedite this process a USAID CA or local agency with policy experience should be funded to develop a concise set of guidelines for male policy leaders.

Long-Term Recommendations

- Designate a USAID CA or local agency to take responsibility to highlight benefits of Men and FP approach in dialogues with national government.

- Designate and fund work by a USAID CA or local agency to work to expand PhilHealth's role in supporting services for men and FP. This would include undertaking a comparative assessment of relative impact of FP services on disability adjusted life years to help justify increased Philhealth coverage.

- Measures must be implemented to ensure that men actually receive services covered under the provisions of the Article 134. A systematic evaluation of the impact of this policy and its utilization by programs should be funded to help clarify useful strategies for reaching men in the workforce.

IEC/BCC AND SOCIAL MOBILIZATION

Short-Term Recommendations

- Fund continued work with MRLs to develop male/couple-oriented mass media to capitalize on successes following the recent fatwa.

- Fund, or tap available resources from USAID IGWG, to conduct training programs for the management and technical staff of social marketing and related mass media agencies to increase their knowledge and awareness gender-equitable approaches to marketing and monitoring results.

- Expand the use of IEC/BCC messages for men and FP that address men's concern for economic realities of supporting a large family. For most if not all the men interviewed, limiting family size is desirable because of the financial problems inherent in having a larger family. Health benefits should not be ignored. There are cases where husbands cite the wife's problems with the last pregnancy as a strong motivation for NSV, but on balance the key issue is economic exigency. Senior NGO respondents felt that the health rationale for FP has been overused and is often subject to controversy on religious grounds, while the economic and environmental rational is a relatively fresh approach that resonates with men and is less likely to generate controversy. The male peer education training used by IPOPCORM includes specific activities to train men in developing a household budget to recognize the importance of not spending money on vices such as drinking and smoking, and to see the implications of having more children for their average family expenditures.

- Extend mobilization with male groups, such as TODAs, MIU, and MRLs with an emphasis on linkage to FP services and an adaptation of the CBMIS approach to identify unmet need (this recommendation is shared by the service delivery assessment);

- Use culturally familiar local and influential public figures for FP messages; enrich IEC handouts and posters with high quality materials that reflect local culture and language.

- Use a couple approach to highlight success stories of satisfied couples and users through personal testimonies both locally and through the media. For example fund efforts to develop video and CD Rom-based testimonies of satisfied NSV client couples who come from nearby local community to show in Barangay Health Centers.

- Conduct a training needs assessment for different levels of FP service delivery (provincial hospital down to barangay health stations) to develop a culturally appropriate training program that will help sensitize both public and private sector service providers for working with men in FP. There are excellent resources available from CAs such as EngenderHealth as well as MSH and UNFPA Training Modules that can serve as a model for training at the province level. Nueva Vizcaya has been designated as a training resource center and should be consulted in this process. This recommendation is shared with the service delivery sub-section below.

- Fund promising programs for both in-school and out of school youth that reach young men. Examples include TUCP programs for working youth, and the community-based Sangguniang Kabataan or Youth Assembly, which may be tapped to educate young men on FP methods, including myths and misconceptions about FP methods like NSC. It is a structure that is largely unused in social development work in the Philippines and it is has the potential to be a partner for FP goals. There is already precedent for this, for example, Marie Stopes has worked with local youth leadership councils, to do training for these youth leaders so they can be peer educators for FP and HIV and AIDS prevention (Dieparine, February 2005).

Long-Term Recommendations

- Encourage expanded use of assets-based community social mobilization with focus on couples based on the approaches taken by Save the Children and PATH Foundation Philippines, Inc with the IPOPCORM project.

SERVICE DELIVERY

Short-Term Recommendations

- Ensure that social acceptance mobilization protocols with large agencies, such as trade unions that serve men, include planning to develop links to tangible FP services. If feasible, this should be combined with efforts to adapt CBMIS approaches to identify unmet need within the membership of these agencies. In making this recommendation it is acknowledged that the TSAP efforts to reach men are relatively recent and therefore these recommendations may not be applicable until a later stage in their social mobilization efforts. Putting too much emphasis on FP services at the initial stages might actually be counter-productive.

- Conduct a training needs assessment for different levels of FP service delivery (provincial hospital down to Barangay Health Station) to develop a training program that will help sensitize both public and private sector FP service providers for working with men in FP. There are excellent resources available from CAs such as EngenderHealth as well as MSH and UNFPA Training Modules that can serve as a model for training at the province level. Nueva Vizcaya has been designated as a training resource center and should be consulted in this process.

- Encourage more couple-oriented healthcare approaches where men are called to accompany and support their wives during pre-natal as well as actual delivery, and post-natal phases. The wives and partners are encouraged to be part of the mechanism for motivating men to take on reproductive and contraceptive responsibilities.

- Facilitate NSV specialist outreach and establish more Philhealth-accredited NSV facilities;

- Consolidate the number of qualified NSV providers through refresher training and expanded training for new practitioners. This can be accomplished in part through "peer training." Peer training refers to the process where municipal health officers or

general practitioners who have been taught NSV can also become trainers who teach NSV to other physicians. This compares to previous practice where specialized NSV trainers are required for training.

- Expand subsidies and PhilHealth reimbursements both within existing PhilHealth-accredited sites and by expanding primary care NSV sites through licensing and accreditation.

- Evaluate the implementation of Article 134 of the Labor Code to rigorously assess quantitatively at the national level, the proportion of companies employing 200 or more individuals that comply and the extent to which both men and women actually receive services covered under the provisions of the policy. This would provide a baseline for evaluating programs in reaching men and women in the workforce and help identify the best strategies for increasing the proportion of companies providing FP services for both men and women.

- Undertake a study to assess the feasibility of FriendlyCare offering high quality urology services for low-income, middle-class and affluent middle-age men, following the successful approach taken by Profamilia/Colombia whereby their large urban FP clinics became financially sustainable in part by developing high quality urology services for clients, who often have chronic prostate care needs (AVSC, 1997c). This is one option for FriendlyCare to increase revenues in the face of imminent phase-out of USAID support.

Long-Term Recommendations

- Fund the expanded use CBMIS at LGU level as an important strategy to reach men in FP;

- Highlight the male involvement in FP approach through expanded subsidy of male methods with assistance from donors, national agencies, LGUs and the private sector.

APPENDICES

APPENDIX A

SCOPE OF WORK

SCOPE OF WORK

I. BACKGROUND

After over 30 years of family planning program implementation in the country, the level of use of modern family planning methods remains at a low 33.4 percent as reported in the 2003 National Demographic and Health Survey (NDHS). This indicates an increase of 5.2 percentage points over the 28.2 contraceptive prevalence rate (CPR) for modern methods reported in the 1998 NDHS. It is also discouraging to note that the share in the CPR of male-specific FP methods (male condom and male sterilization) was only 1.7 percentage points in 1998 and 2.0 percentage points in 2003.

Surveys have shown that women wanting to use a family planning method decide otherwise due to opposition from their spouses. In the 1998 NDHS, more women (5.5 percent) reported "opposition from husband" as reason for their non-use of contraception as opposed to non-use due to religion (4.8 percent). Surveys have likewise shown that on the average, the ideal number of children desired by Filipino men is higher than the ideal number of children desired by Filipino women. In the 1998 NDHS, 20 percent of women respondents reported that their partners want more children than they do.

Demographers, social scientists and family planning implementers have repeatedly pointed out that among the major weaknesses of the family planning program in the country is its focus on women and corresponding disregard in involving men. A recent assessment of the USAID-supported social acceptance project in family planning in the Philippines notes that, "the decision to focus on males is long overdue considering findings from various researches about the key role of men in the Filipino couple's decision to practice or not to practice family planning."

II. OBJECTIVES OF THE ASSESSMENT

The proposed assessment of male involvement in family planning in the Philippines aims to take a critical analysis of studies and related literature that has been done on Filipino males and family planning in the Philippines; and review current program policies and determine how they are contributing/not contributing to greater male involvement in family planning; and assess family planning projects and activities and attempts, if any, to consider men, in the design and implementation of these projects and activities. The assessment shall identify strategies and practices that are friendly and/or unfriendly to men and come up with appropriate recommendations. Results of the assessment shall be used as inputs in strengthening male involvement in family planning communication and service delivery activities in the country.

The objectives of the mid-term assessment are:

1. To gather, review and do an in-depth analysis of studies and related literature that have been done on Filipino males and family planning in the Philippines;

2. To review current program and operational policies and guidelines and determine how they are enhancing or discouraging greater male participation in family planning;

3. To assess family planning projects and activities and attempts, if any, to consider men, in the design and implementation of these projects and activities; and

4. To identify strategies and practices that are friendly and/or unfriendly to men and come up with appropriate recommendations to encourage/strengthen male participation in current communication and service delivery activities. These shall include, but shall not be limited to: identifying male-specific family planning messages including male-friendly information, education, communication (IEC) and counseling strategies and approaches; and effective FP service delivery programs for males.

III. USAID'S POPULATION, HEALTH AND NUTRITION RESULTS FRAMEWORK

The strategic objective of USAID's Population and Health Program (Strategic Objective 3) is: Desired Family Size and Improved Health Sustainably Achieved. SO 3 has four intermediate results, which if achieved, will lead it is believed to the achievement of the strategic objective. The Intermediate Results (IRs) are:

IR 1: Local Government Unit (LGU) provision and management of FP/MCH/TB/HIV/AIDS services strengthened;

IR 2: Provision of quality services by private and commercial providers expanded;

IR 3: Greater social acceptance of family planning achieved; and

IR 4: Policy environment and financing for provision of services improved.

The first two IRs are directed toward improving the efficient, effective, and sustainable delivery of health and family planning services in the critical areas of local government and the private health sectors where most health services are delivered. The last two IRs focus on developing the engines of change that will provide the invigorated atmosphere within which services will be provided. They will take steps necessary to develop the positive and person-oriented approach necessary to create an environment for change. The successful implementation of the four IRs necessitates that concerns of males, which comprise half of Filipino couples, are duly considered in the design and implementation of activities under all the IRs.

IV. RESOURCES AND PROCEDURES

A. Data Sources

The assessment team will review program research studies and documents, including but not limited to the following:

1. 1998 and 2003 NDHS Reports;
2. Data from the 2003 NDHS male module;
3. Family planning surveys, 1995-2004;
4. Project design, LEAD for Health Project;
5. Project design, (FP) Initiatives in the Private Sector;
6. Project design, The Social Acceptance Project-Family Planning;
7. Status reports, Past and Present Male Sterilization Activities;
8. Research reports on male involvement in FP in the Philippines and other countries.

The team will conduct personal interviews with local program staff of the various USAID cooperating agencies (CAs) operating in the Philippines. A select number of local partners and stakeholders will likewise be interviewed including relevant government agencies like the Department of Health (DOH), the Population Commission (POPCOM), and the Philippine Health Insurance Corporation (PHIC). Local experts and authorities on the subject matter from the academe will likewise be interviewed. The team will meet with key technical staff of USAID/Philippines and selected representatives from various donor agencies in the country. The assessment team will conduct individual and group interviews with male groups/organizations and male sterilization clients to generate feedback on their experiences and solicit suggestions and recommendations to strengthen and widen the reach of the country's male sterilization program.

B. Methods of Data Collection

Prior to the assessment team's arrival in the Philippines, staff from the Office of Population, Health and Nutrition (OPHN) of USAID/Philippines will gather relevant project documents and send them to members of the assessment team for review. In-country work will include meeting with the OPHN Chief and other OPHN staff, interviews with local staff of selected USAID-supported cooperating agencies, representatives from selected donor agencies, government and nongovernment organizations, the academe and other local partners and experts. Field trips to do field interviews and/or focus group discussions (FGDs) of male groups and male sterilization clients will be carried out. Review and in-depth analysis of relevant studies including NDHS reports and annual family planning surveys will likewise be undertaken.

C. Duration and Timing of the Evaluation

The assessment will begin in about the second week of November 2004. If feasible, in-country work will start on or about November 15, 2004 and will run for three weeks. A draft report will be submitted by the team immediately after the in-country assessment (on or about December 3, 2004). Comments on the first draft report are due after two weeks (on or about December 17, 2004). Once the team leader receives comments on the first draft, he/she will have two weeks to incorporate them into the final report. A time line is outlined below:

Week 1: Review of relevant project documents
Week 2-4: In-country fieldwork

Week 4: Preparation of draft report and debriefing meeting with USAID
Week 5-6: USAID/Philippines comments on draft report
Week 7-8 Team leader incorporates comments and finalizes report
Week 10: Final report printed and ready for distribution

A detailed outline of the key findings and recommendations, among others, should be incorporated into the draft report to be provided to USAID/Philippines after the fieldwork is completed. The final report should be printed and ready for distribution not later than January 14, 2005.

D. Team Composition

The evaluation team will consist of three consultants with technical expertise and experience as described below. In addition to the right combination of technical skills, the team should also be diverse and balanced in terms of gender and culture. The three will be:

1. A Family Planning Project Design Specialist who has worked in the Philippines or at least in Asia in the area of male involvement with experience in the design and implementation of FP communication and/or service delivery activities.

2. A Social Scientist, preferably Filipino who is abreast with current trends and issues in family planning and male involvement with extensive experience in social science research.

3. A Family Planning Program Manager, preferably Filipino who has extensive experience in FP/RH program implementation in the Philippines.

E. Funding and Logistical Support

All funding and logistical support for the assessment of male involvement in family planning in the Philippines will be provided through the POPTECH Project of the Office of Population. Activities that will be covered include recruiting and supporting the assessment team, funding all expenses related to the assessment, providing logistical support including setting up meetings in the Philippines, and producing and dissemination of the assessment report.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Carina Stover, Chief, Office of Population Health and Nutrition
Aye Aye Thwin, Population Development Officer, OPHN
Catherine Fischer, Senior Technical Advisor, OPHN
Ma. Paz de Sagun, Project Management Specialist, OPHN
Ephraim Despabiladeras, Project Management Specialist, OPHN
Nilda Perez, Project Management Specialist, Population, OPHN
Corazon Manaloto, Development Assistance Specialist, OPHN
Charito Redoblado, Project Management Specialist, OPHN
Wesley Dulawan, Project Development Specialist, OPHN
Carina San Felix, Project Management Specialist, OPHN
Sarah Diama, Development Program Specialist, Program Resources Management
Fatima Verzosa, Project Development Specialist, Program Resources Management

UNITED NATIONS POPULATION FUND (UNFPA)
Zahidul Huque, Country Representative
Auralyn Anorico, Programme Officer for Adolescent Reproductive Health

DEPARTMENT OF HEALTH (DOH)
Honorata Catibog, Director, Family Health Office
Florencia Apale, Medical Specialist IV, Family Health Office
Diego Danila, Medical Specialist III, Family Health Office

COMMISSION ON POPULATION (POPCOM)
Mia Ventura, Deputy Executive Director
Rose Marcelino, Regional Director, National Capital Region
Lolita Layser, Regional Director, Region IV
Victoria Corpuz, Planning Officer V

PHILIPPINE HEALTH INSURANCE CORPORATION (PhilHealth)
Eduardo Banzon, Vice President for Health Finance Policy and Service Sector

ARMED FORCES OF THE PHILIPPINES (AFP)
Rafael Regino, Surgeon General

DKT PHILIPPINES
Benny Llapitan Jr., Marketing Director
Dennis Abanid, Assistant for Special Projects
Lady Suñega, Senior Assistant for Research, Monitoring and Evaluation

FRIENDLYCARE FOUNDATION, INC. (FCFI)
Leni V. Cuesta, President
Alberto Romualdez, Jr., Member of the Board of Trustees/Former Secretary of Health
Luis Garcia Jr., Director, Health Service and Quality Division
Cynthia Herce, Training Coordinator

LEAD FOR HEALTH PROJECT/MANAGEMENT SCIENCES FOR HEALTH (MSH)
Jose Rodriguez, Director Family Planning and Health Systems Unit
Florante Magboo, Field Operations Manager
Cesar Maglaya, Clinical Training Advisor and Family Planning Specialist

PATH FOUNDATION PHILIPPINES, INC.
Carmina A. Aquino, Executive Vice President
Joan Regina L. Castro, Project Director, IPOPCORM

PRIVATE SECTOR MOBILIZATION FOR FAMILY PLANNING (PRISM)/ CHEMONICS
Grace Migallos, Deputy Chief of Party
Alejandro San Pedro, Private Practice Director
Mia Aquino, Gender Specialist
Raul Caceres, BCC Specialist

SAVE THE CHILDREN
Naida Pasion, Acting Country Director

THE SOCIAL ACCEPTANCE PROJECT–FAMILY PLANNING (TSAP–FP)
Eleanora de Guzman, Chief of Party
Cecilia Lantican, Deputy Chief of Party
Ricardo Gonzales, Medical Advisor
Romeo Arca, Advocacy Advisor
Felix Bautista Jr., Communication Advisor
Rosario Maria Nolasco, Capacity Building Specialist/ Communications
Ramon Espiritu, Procurement Specialist
Regi Greja Canda, Advocacy Specialist
Filipinas Santos, Civil Society Mobilization Specialist
Fe Manapat, Local Area Coordinator for Advocacy
Jerome Zayas, Local Area Coordinator for Advocacy

FAMILY PLANNING ORGANIZATION OF THE PHILIPPINES (FPOP)
Rhodora Raterta, President
Julio Lasete, Head of Program Operations Group
Dionisia Posadas, Consultant for Governance and Accreditation

KAANIB (SDM PRACTIONERS)
Helen Ayre
Wilma Ayare
Leonida Caballero
Noel Ayare
Vivencio Caballero
Arlene Tintay-Sayago
Raul Dumadag
Daniel Cobiag
Beverly Dumadag
Luz Cobiag
Rosita Antonio

NATIONAL CONFEDERATION OF TRICYCLE OWNERS & DRIVERS ASSOCIATIONS OF THE PHILIPPINES (NACTODAP)
Ariel Lim, National President

PHILIPPINE NGO COUNCIL
Maricar Vallido, Deputy Executive Director

POPULATION SERVICES PILIPINAS INC. (PSPI)
Virgilio Pernito, Executive Director
Rostom Deiparine, Chief Operating Officer
Frank Francisco, Technical Officer

REACHOUT FOUNDATION INTERNATIONAL
Jomar Fleras, President/ Chief Executive Officer

TRADE UNION CONGRESS OF THE PHILIPPINES (TUCP)
Ariel Castro, Director for Education
Rafael E. Mapalo, Project Manager, Education Office

BAGO CITY
Pilar Mabasa, City Health Officer
Daisy Enriquez, Family Planning Nurse Coordinator
Nona Ubando, Nurse Supervisor
Jocelyn Cusay, Barangay Health Midwife

CAGAYAN DE ORO CITY
Magdalena Cabaraban, Research Institute for Mindanao Culture, Xavier University

CEBU CITY
Delia Evardo, Sacred Heart Hospital Reproductive Health Clinic
Frownie Cagalitan, Sacred Heart Hospital Reproductive Health Clinic
Saleshe Baking, Vicente Sotto Memorial Medical Center
Bernazen Abuban, Nurse, Vicente Sotto Memorial Medical Center
Erlinda Mariño, Midwife, Vicente Sotto Memorial Medical Center
Judy Aguilar, University of San Carlos Sociology & Anthropology Research
Connie Gultiano, University of San Carlos Office of Population Studies
Jojo Avila, University of San Carlos Office of Population Studies
Maria Pina Buanghug, Chairman, Cebu City United Vendors Association
Celia Quimpoy, Secretary, Cebu City United Vendors Association
Lucy Lingongan, Treasurer, Cebu City United Vendors Association
Raul Acompañado, PRO, Cebu City United Vendors Association
Peter Ferolino, PRO, Cebu City United Vendors Association
Rodulfo Limpang, Staff, Cebu City United Vendors Association
Rico Tanuran, Staff, Cebu City United Vendors Association
Edwin Leung, Philippine Business for Social Progress Visayas Office
Timotheo Ochea, Barangay Secretary, Sabang
Casimero Tisog, Barangay Councilor, Sabang
Francisco Santillan, Barangay Councilor, Sabang

Dahlia Inac, Public Health Nurse, Sabang Health Center
Maricel Cañete, Barangay Health Worker, Sabang Health Center
Marjorie Ompad, Barangay Health Worker, Sabang Health Center
Celda Butalid, Barangay Health Worker, Sabang Health Center
Apolinaria Evangelista, Barangay Health Worker, Sabang Health Center
Adelina Sagarino, Barangay Health Worker, Sabang Health Center
Efren Tabanao, Regional Coordinator, National Confederation of Tricycle Owners and Drivers Association of the Philippines

COMPOSTELA VALLEY
Manuel Brillantes Jr., Municipal Mayor, Monkayo
Olivia Lanaban-Kapoor, Municipal Health Officer, Monkayo
Bunaliza Glem, Municipal Health Officer, Mabini
Elizabeth Cudao, Barangay Health Nurse, Mabini
Marylyn Aventado, Rural Health Physician, City Health Office
Luz Anung, Management Sciences for Health
Edgar Lugnasin, Monkayo High School
Reynato Alfon, Mabini
Mesan Engula, Mabini
Marwin Lendio, Compostela

COTABATO CITY
Tato Usman, Medical Specialist, DOH–ARMM Regional Office
Ustadz Ahmed Mala, Arabic Teacher
Eva Kimpo-Tan, TSAP Field Coordinator
Nawira Rasdi, Executive Director, Bangsa Moro Women Foundation for Peace and Development
Amina Emblawa, Bangsa Moro Women Foundation for Peace and Development
Nurtruda Simpal, Bangsa Moro Women Foundation for Peace and Development

DAVAO CITY
Warlito Vicente, Chairperson, the Well Family Partnership Foundation Inc.
Anita Alojado, Clinic Manager, Well Family Midwife Clinic, Bangkal
Lita Sealza, Research Institute for Mindanao Culture, Xavier University

DAVAO DEL NORTE
Areonito Lamerte, Administrative Officer, Provincial Health Office
Eugene Arado, Family Planning Coordinator, Provincial Health Office
Gloridita Oclait, Surgical Networking Program Coordinator
Niptalez Avena, Maternal & Child Health Coordinator, Provincial Health Office
Mona Feo Ycapin, Nurse, Carmen District Hospital
Reynaldo Villanueva, Chief of Hospital, Saman District Hospital
Jean Escaban, Chief of Hospital, Carmen District Hospital
Gregorio Facula, Municipal Mayor, Municipality of Braulio E. Dujali
Cherry Demaala, Municipal Health Officer, Municipality of Braulio E. Dujali
Jovelyn Dumaluan, Nurse
Jester Makol, MSA
Mario Saladas, Media, Trends & Time
Johnny Peralta, Chief of Hospital, PGO

Romulo Espinas Sr., Councilor, Municipality of Braulio E. Dujali
Mafel Roferos, Public Health Nurse, Panabo City

KIDAPAWAN CITY
Rey Catague, Provincial Health Officer
Virgie Laquihon, Family Planning Coordinator
Reil Layos, Philippine National Police
Dionisio Arcenio, Philippine National Police
Gregorio Natuasevez, Philippine Nacional Police
Artemio Parreno, Philippine Army

MALAYBALAY, BUKIDNON
Maria Rica Raguro, Nurse of the Malaybalay City Health Office
Katherine T. Toledo, City Health Officer

NUEVA VIZCAYA
Luisa Loren Cuaresma, Governor
Ferdinand Tolentino, Provincial Health Officer
Edwin Galapon, Provincial Manager for Reproductive Health
Elvira Tongson, Provincial Population Program Officer
Anthony Cortez, Municipal Health Officer, Bambang
Dolores Dacanay, Nurse IV, Provincial Health Team
Vivian Dumangeng, Nurse III, Provincial Health Team
Melchor Dumangeng, President, Male Reproductive Health Federation
Mariano Bulet, Treasurer, Male Reproductive Health Federation
Edwin Ollo, Barangay Captain, Sta. Cruz, Bambang
Roger Sebastian, Barangay Councilor, Sta. Cruz, Bagabag
Adore Bulet, Barangay Councilor, Sta. Cruz, Bagabag
Abraham Laya, Barangay Councilor
Glenn Afalla, Barangay Sangguniang Kabataan Chairman
ClaroTubayan, Minister United Methodist Church

VALENCIA CITY, BUKIDNON
Marlyn Agbayani, City Health Officer
Ismael Naypa, Private Practitioner
Ruel Rondina, NSV Acceptor
Virgie Rondina, Wife

APPENDIX C

FINAL SCHEDULE FOR ASSESSMENT

FINAL SCHEDULE FOR ASSESSMENT

Date		Venue	Remarks
February 7 (Monday)	9:30 AM: Briefing of the TEAM at USAID Team Meeting	Conference Room 2, USAID 8th Floor PNB Financial Center, Diosdado Macapagal Blvd., Pasay City	Confirmed
	2:00 PM: Meeting with Director Tom Osias and POPCOM staff	Board Room, POPCOM, Welfareville Compound, Mandaluyong City Tel.5316735	Confirmed
	4:00 PM: Meeting with Lief Doerring, Grace Migallos, Aurora Perez of PRISM	Chemonics/ PRISM Office Unit 1905 Galleria Corporation, EDSA corner Ortigas Avenue, Pasig City Tel. No. 3972365/ 3972361 to 64	Confirmed
February 8 (Tuesday)	8:00 AM: Meeting with Mr. Ariel Castro of TUCP	Trade Union Congress of the Philippines (TUCP) Maharlika corner Masaya Streets, Diliman, Quezon City	Confirmed
	10:00 AM: Meeting with Atty. Rhodora Raterta of FPOP	Family Planning Organization of the Philippines (FPOP) 50 Hemady St., New Manila, Quezon City (Tel. 7217302/ 7217101)	Confirmed
	1:00 PM: Meeting with Nora de Guzman, Cecile Lantican, Romy Arca of AED	Academy for Educational Development (AED) 8th Floor Ramon Magsaysay Center, Roxas Boulevard, Ermita, Manila Tel.536-0689/ 5360681/ 5360692	Confirmed
	4:00 PM: Meeting with Deputy Executive Director Maricar "Chi" Vallido of PNGOC	Philippine NGO Council (PNGOC) Unit 304 Diplomat Condominium Bldg., Russel Avenue corner Roxas Blvd., Pasay City Tel. No. 8334067	
February 9 (Wednesday)	9:00 AM: Meeting with Mr. Jomar Fleras of ReachOut	ReachOut Foundation International 3/F Unit B, Miriam House, Legaspi St., Legaspi Village, Makati City Tel. No. 813-5702/8170835 (fronting Equitabl bank & Planters Bnak/ besides CAP Bldg. at the corner of Legaspi St. is Starbucks)	Confirmed
	11:00AM: Meeting with Dr. Luis Garcia, Jr. and Ms. Cynthia Herce of FriendlyCare, Inc.	FriendlyCare Foundation,Inc. 710 Shaw Boulevard, Mandaluyong, Tel. No. 7222968	Confirmed
	1:30 PM Mr. Benny Llapitan, Dennis Abanid; Ms. Lady Suñega	DKT Philippines, Inc. Suite 801, The Lenden Suites, 37 San Miguel Avenue, Ortigas Center, Pasig City (Look for Ms. Joan)	
February 10 (Thursday)	8:00 AM Breakfast meeting with Dr. Alberto Romualdez	Pacific Lounge, 21st Floor Pan Pacific Hotel, Adriatico corner Malvar St., Ermita, Manila	Confirmed
	Team Meeting	Pacific Lounge, 21st Floor Pan Pacific Hotel	
	2:30 PM Meeting with Dr. Catibog and DOH staff	2nd Floor Building 13, Family Health Office,	Confirmed

		Department of Health, San Lazaro Compound, Sta. Cruz, Manila Tel. No. 7329956	
February 11 (Friday)	9:00 AM Meeting with Mr. Ariel Lim of NACTODAP	Nat'l Confederation of Tricycle Operators & Drivers Association of the Philippines.(NACTODAP) Room 403 Tahanan ng Masa Building, Malacañang Complex, Manila Telephone No. 7368634/ 7366887	Confirmed Confirmed
	11:00AM Meeting with Naida Pasion of Save the Children	Save the Children #1 Encarnacion St., corner Lapu-lapu Ave., Magallanes Village,Makati City	Confirmed
	2:00 PM Meeting with Dr. Zahidul Huque & Ms. Auralyn Anorico of UNFPA	United Nations Population Fund (UNFPA) 30th Floor Yuchengco Tower, RCBC Plaza, 6819 Ayala Avenue, Makati City	Confirmed
	4:00 PM Meeting with Dr. Joe Rodriguez, Dr. Sonny Magboo of MSH/LEAD	Ambasssador's Sala Function Room, 2nd floor TRADERS HOTEL, Roxas Blvd.(fronting CCP Complex)	

Date	Activities	Logistic Requirements	Remarks
February 13 (Sunday)	**For: Dr.Sam Clark, Dr. Romie Lee & Mr. Harris Solomon** 7:00 AM Pick up at the Pan Pacific Hotel lobby(Rented Car) Departure to Bayombong, Nueva Vizcaya Contact Numbers: Dr. Edwin Galapon 0919-8334688 (078)321-2609 or 321-2610 Bayombong, Nueva Vizcaya Dr. Anthony Cortez 0919-5975925 (078)8031896 or 8032240 Bambang, NV **For: Dr. Pilar Jimenez** Departure to Cotabato City 2:00 PM FGD with MRLs 6:00 PM Dinner with Ms. Nawira Rasdi, Executive Director of Bangsa Moro Women Foundation for Peace & Development (BMWFPD) at the hotel Contact Number: Ima Versoza 0917-8393434 Nawira Rasdi (064)421-6154 **For: Dr. Jondi Flavier & Ephraim Despabiladeras** Departure to Davao City	Manila – Nueva Vizcaya (Car Rental) 7:00 AM Rented car (Toyota Revo) will pick them up PAN PACIFIC HOTEL Lobby Accommodation: Faber Inn, Bayombong, Nueva Vizcaya Tel. No. (078)321-2222 Room Rate: P850 per night Manila- Cotabato PR 187 10:10AM – 11:45AM Accommodation: Estosan Hotel, Cotabato City Tel. No.: (064)421-6777 to78 Room Rate: P1,440 Manila-Davao PR 813 3:40 – 5:25PM Accommodation: Grand Men Seng Hotel Magallanes corner Anda Streets, Davao City Tel. No.: 082-2219040 Room Rate: P 1,396 with breakfast Note: Hotel airport pick up	
February 14 (Monday)	**For: Dr. Clark; Mr. Solomon & Dr. Lee** 8:30 AM Courtesy call to the Governor of Nueva Vizcaya Meeting at the Provincial Health Office	Another rented car will be in Bayombong which will bring Dr. Lee back to Manila from Nueva, Vizcaya while the Toyota Revo will be used by Dr. Sam & Mr. Harris until February 15 when they go back to Manila	

	PM FGD in Sta. Cruz (Dr. Edwin Galapon will accompany the TEAM) **For: Dr. Pilar Jimenez** AM Leave early morning for Amas, Kidapawan 10AM Interview with Dr. Ray Catague and PHO staff Interview with Men in Uniform Contact Number: Ms. Virgie Laquihon # 0910-8482995 **For: Dr. Jondi Flavier & Mr. Ephraim Despabiladeras** AM Interview with Dr. Agapito Hornido, Provincial Health Officer, Davao Norte on Male RH Centers and site visits to selected Male RH Centers PM Visit Well Family Midwives Clinic	 Accommodation: AJ Hi Time Hotel, Amas, Kidapawan Dr. Hornido/FP Coordinator will represent Dr. Hornido Contact: Ms. Luz Anung, FC-MSH/LEAD Mobile #0920-9248690	
February 15 (Tuesday)	**For Dr. Sam Clark & Mr. Harris Solomon** - Will go to Bambang, Nueva Vizcaya for interview at the Municipal Health Office (Dr. Anthony Cortez) - Departure by mid-day to Manila **For Dr. Pilar Jimenez** Leave for Davao City **For Dr. Flavier & Mr. Ephraim Despabiladeras** Observe Mayor's Day activities in Monkayo, Compostella Valley, including NSV camp and interviews with the Mayor, health officials, and NSV clients **For Dr. Flavier, Mr. Ephraim Despabiladeras & Dr. Pilar Jimenez** Meeting in Davao City to compare notes	Nueva Vizcaya – Manila Kidapawan – Davao City Accommodation: Grand Men Seng Hotel Magallanes corner Anda Sts. Davao City Tel. No.: 082-2219040 Room Rate: P 1,396 , with breakfast Contact Person: Dr. Olivia Kapoor, Monkayo, Compostella Valley Mobile#0921-7438383	
February 16 (Wednesday)	**For Dr. Flavier , Mr. Ephraim Despabiladeras & Dr. Pilar Jimenez** 7:00 AM Departure from Davao City to Valencia, Bukidnon by hired car PM Interview in the afternoon with Dr. Ismael Naypa on NSV in the private sector, proceed to Malaybalay for hotel check-in **For Dr. Sam Clark; Dr. Romie Lee & Mr. Harris Solomon** 9:00 AM Meeting with Dr. Eduardo Banzon of PhilHealth	Davao City – Bukidnon Accommodation: Pine Hills Hotel, P & T Town Center Fortich Street 8700 Malaybalay, Bukidnon Tel. No. (088) 221-3211 (088) 221-3214 Room Rate: 1,380; w/out breakfast Room 1912 19th Floor City State Center, 709 Shaw Blvd., Pasig City Tel.No. 687-3129	Confirmed

	11:00AM Meeting with Brigadier General Rafael Regino, AFP Surgeon General **For Dr. Sam Clark; Dr. Romie Lee, Mr. Harris Solomon & Ms. Carina Stover** Departure from Manila to Bacolod City by PAL	Office of the Surgeon General, Camp Aguinaldo, EDSA, Quezon City Mobile No.: 0920-6163093 (BGen. Regino) Manila – Bacolod PR 135 4:05 – 5:15PM Accommodation: L'Fisher, Lacson Street, Bacolod City Tel. No.:034-4333731 to 39 Room Rate: P2,000 credit card payment 1,750 cash payment, with buffet breakfast Note: Hotel pick up at the airport : Feb.16 Hotel Arrangements: Delux Rooms already available as of Feb.14, guest need not transfer from super deluxe to deluxe on Feb.17.	Confirmed
February 17 (Thursday)	**For Dr. Sam Clark; Dr. Romie Lee, Mr. Harris Solomon & Ms. Carina Stover** 7:30AM Leave Bacolod City to Bago City 8:30AM City Health Office in Bago City to observe NSV service delivery & interview local health officials 9:30AM Do FGD with NSV acceptors and their wives still at the City Health Office 12:00NN Meeting with the Mayor over lunch PM Depart for Bacolod City **For Dr. Flavier, Mr. Ephraim Despabiladeras & Dr. Pilar Jimenez** AM Dr. Jimenez to discuss DM with Malaybalay Bishop 2:00 pm FGD with KAANIB farmers & wives Depart for Cagayan de Oro City	Dr. Pilar Mabasa, City Health Officer, Bago City Mobile Number: 0917-3000764 **Car Rental** going to Bago City c/o Mr. Melo Co Mobile# 0919-8486667 Van = 1st 3 Hours is P1,000 then succeeding hour is P250 per hour (gasoline not included in the rental, approximately P300) **Ms. Pierra Fuentespina** (FGD) Mobile#0916-4202419 Malaybalay, Bukidnon – Cagayan de Oro City Accommodation: Dynasty Court Hotel, Tiano corner Hayes Streets Cagayan de Oro Tel. No.: (088)857-5900/ (08822)724-516 Room Rate: P1,500, with breakfast	Confirmed
February 18 (Friday)	**For Dr. Sam Clark; Dr. Romie Lee, Mr. Harris Solomon & Ms. Carina Stover** Depart Bacolod City for Cebu City 9:00AM 10:00 am – Sacred Heart Hospital RH Clinic NSV Program Southwestern University c/o Dr. Delia Evardo & Ms. Frownie Cagalitan (#0927-5719399) 10:30AM – 11:30AM- FP Clinic of Vicente Sotto Medical Center c/o Dr. Saleshe Baking 1:30pm – 2:30 pm - University of San Carlos Sociology and Anthropology Research (SOAR) Group c/o Prof. Judy Aguilar and OPS (Ms. Connie Gultiano & Jojo Avila)	Bacolod – Cebu (Cebu Pacific)7:00am – 7:35am Accommodation: Cebu Midtown Hotel, Fuente Osmeña, Cebu City Tel. No.: 032-2529711 Room Rate: P1,700 , w/o breakfast (Special rate for flying Cebu Pacific from Bacolod to Cebu) Note: No airport pick up	Confirmed

	3:30PM – 5:00PM - Cebu City United Vendor's Association (CCUVA) 2/F Carbon Market Complex,Cebu City c/o Ms. Maria Buanghug, President **For Dr. Flavier , Mr. Ephraim Despabiladeras & Dr. Pilar Jimenez** AM Meetings with other stakeholders in CDO PM Depart Cagayan de Oro for Manila	 **For Dr.Jimenez & Mr. Ephraim Despabiladeras:** Cagayan de Oro City- Manila PR 186 2:50pm – 4:15pm **For Dr. Flavier:** Cagayan de Oro City – Manila PR 182 7:40am-9:05am	
February 19 (Saturday)	**For Dr. Sam Clark; Dr. Romie Lee, Mr. Harris Solomon & Ms. Carina Stover** 8:00AM -10:00AM To Olango Island (Mr. Edwin Leung, Project Officer of PBSP Olango will pick up the team at Cebu Midtown Hotel) 10:00AM 11:00AM – Meeting with Barangay Officials and some fishermen Bird Sanctuary Center Olango Island 11:00am -1:00PM – To Mactan for lunch then proceed to Compostela Municipal Hall (Mr. Jerome Zayas of AED will accompany the team) #0917-8558925 2:00pm –3:00pm - Meeting with NACTODAPP Leaders in Metro Cebu 3:00pm -4:00pm – To Mactan Airport 5:30pm –6:40pm- Depart Cebu to Manila	 Mr. Edwin (Kiang) Leung contact number 0918-9136484 PBSP Visayas Office is located at the 4th Floor of PLDT Bldg. Mabolo, Cebu City Mr. Efren Tabanao, Regional Coordinator NACTODAP Central Visayas , Compostela, Cebu Municipal Hall (Mobile#0927-3665517 Cebu – Manila PR 850 5:30PM	Confirmed Confirmed

APPENDIX D

POPCOM MATRIX OF PROGRAMS RELATED TO MEN AND FAMILY PLANNING

POPCOM MATRIX OF PROGRAMS RELATED TO MEN AND FAMILY PLANNING

COMMISSION ON POPULATION
MATRIX ON THE MALE INVOLVEMENT ON REPRODUCTIVE HEALTH AND FAMILY PLANNING
CY 2004

REGION REGION	PROJECT TITLE PROJECT TITLE	DESCRIPTION DESCRIPTION	SPECIFIC AREASPECIFIC COVERAGEAREA	ACTIVITIES/ACCOMPLISHMENTS ACTIVITIES/ACCOMPLISHMENTS	FUNDING SOURCEFUNDING SOURCE	STATUS STATUS
			COVERAGE			
NCR	Family Planning Day Celebration (2003 and 2004)	An annual event celebrated every 1st day of August to highlight significance of FP in national development. The NCR theme of 2003 and 2004 was on men's responsible involvement in Family Planning. 2003 slogan: "Papa Kasama Ka Sa Pagpaplano ng Pamilya." 2004 slogan: "Ang Machong Papa Nagpaplano ng Pamilya". Other sub-themes from civil society: "Sigaw ng Bayan: Mag-Family Planning na ng Buhay Guminhawa". DOH national theme: "Pamilyang Nakaplano, Siguradong Bright Child ang Anak Nyo."	Metro Manila	FP Day activities undertaken in: 2003 • Motorcade around San Juan and nearby cities (Pasig, Makati, and Quezon City) • Program with messages from LCE, POPCOM, DOH-NCR directors, NGO heads and donor agency representatives • Slogan contest • Men's Forum • Exhibits and provision of FP services. 2004 • Tricycle Chain around Quezon City Memorial Circle • Program with messages from LCE, National legislator, NGA, NGO and donor agency representatives; and stage plays. • Testimonials of NSV practitioners • Exhibit and FP services • Press conference attended by representatives from almost all newspapers, TV and radio networks in Metro Manila	AED P100,000	Completed (Aug.1, 2003-20
				• Exhibit and FP services • Press conference attended by representatives from almost all newspapers, TV and radio networks in Metro Manila		
NCR	TODA orientation on FP	Half day orientation of members tricycle operators and drivers association (TODA) on family planning and responsible parenthood. family planning and responsible parenthood.	Metro Manila	Increased awareness and acceptance of family planning among members of TODA.	AED	Complete October 1, 2
NCR	Men's Forum	Half day orientation on FP among members of the informal sectors such as the vendors, street sweepers, jeepney drivers the informal sectors such as vendors, street	San Juan	Increased awareness and FP acceptance among informal sectors particularly NSV.	LGU	Complete July 200

		sweepers, jeepney drivers.				
NCR	ERPAT Forum	Orientation on family planning and responsible parenthood among fathers. Erpat is a local term for father. parenthood among fathers. Erpat is a local term for father.	Caloocan	Increased involvement of fathers in family planning including household chores.	LGU	Continuin July 200
NCR	"Usapang Lalaki"	FP Orientation of bus and jeepney drivers in Marikina City done in coordination with the Marikina City LTO. Marikina City done in coordination with the Marikina City LTO.	Marikina	Increased awareness, consciousness acceptance of FP among bus and jeepney drivers.	LGU	Continuin July 200
NCR	Industry -based orientation on FP	Conduct of FP orientation among employees in male dominated companies such as Fortune tobacco. of male dominated companies such as Fortune tobacco.	Metro Manila	Increased FP awareness and acceptance including productivity in companies. including productivity in companies.	LGU	2005 1st Quarte
NCR	Oplan Family Planning	Community Outreach for family planning for husbands and wives needing family planning.	Quezon City Pasig City Caloocan City Las Pinas City Valenzuela City	Increased FP awareness and acceptance	LGU	Continuin July 200
NCR	Art for a Cause	An art exhibit on reproductive health participa- ted in mostly by male artists (painters,scuptors, etc.) launched by QCCP in September 2004 at the GSIS museum. The artists were given orientation on reproductive health to help them better express and communicate RH in their art work. Proceeds from the sales shall be used for RH needs in Quezon City.	Nationwide	Increased awareness, understanding and appreciation of FP through the art.	QCCP	Complete September 2 December 2
NCR	Continuous FP Information, Education, Communication Motivation (IECM) service provision	The BSPOs and BHWs continue to motivate and refer clients particularly male for NSV for those who would want to limit their children and condom for those who would like to space their children. Trained doctors regularly perform NSV to referred and walk-in clients. and refer clients particularly males for NSV for those who would want to limit their children and condom for those who would like to space their children.Trained doctors regularly con- duct NSV to referred and walk-in clients.	Metro Manila	Increased FP acceptance/practice among males.	DOH LGU	Continuin 2000 to pres
CAR	Increasing Male Participation in Reproductive Health (RH)	This is an expanded project of RPO-CAR with the following objectives: to a) increase the number of male advocates; &	Cordillera Adminis- trative Region Baguio City Apayao	The beneficiaries of the activity were the male faculty professors/instructors of the various departments of the University of Baguio.	P 30,000.00 (initial)	This is a con ning project since 1998. In the absence of funds

		b) increase awareness and appreciation among men on Gender and Development (GAD) and Reproductive Health (RH)	Academe: - University of Baguio - Saint Louis University	Male RH and gender issues and concerns were discussed during the seminar-workshop. Come up with action plans that promote RH participation of males in the LGUs,RPO and the Organization of Mechanical Engineers	LGU funds Tie-up with FPOP, BCYA and DepEd	Academe,LG schools are tinuing the activity on their own funding sour
Region II	Holding up the Other Half of the Sky - *Male Involve-ment in RH* - Male Reproductive Health Association	This is a barangay-based pilot project of the Male RH Association implemented in the Barangay of Caloocan of Bambang, Nueva Vizcaya where RH providers actively sought ways to better understand men & help them take care of themselves and their families.	Bambang, Nueva Viscaya	-Series of lectures, seminars and short training courses were given to different sectors, starting with the barangay cap-tain, his council and the barangay tanods. -Dissemination of information were continued down to the purok level. -Lectures and seminars were conducted once or twice a week for about six months.		Started in 20 to end this 2 under the UNFPA 5th Country Project
Region II	Using elected community local officials to enhance male involvement in RH	The project encourages husbands and male adolescents to increase their participation in the RH program particularly on FP, STD/HIV/AIDS, gender and sexuality, male RH, ARH and VAW. Strategies used are organization of male community leaders in the community, training them as motiva-tors and peer counselors, encouragement of males on FP counselors and getting males as source of FP support.	Cagayan and Nueva Vizcaya Bambang, N. Vizcaya Abulug, Cagayan Gattaran, Cagayan Solana, Cagayan Camalniugan, Cag. Rizal, Cagagayan Sta. Teresita, Cag. Aparri, Cag. Baggao, Cagayan	-Organization and training of male community leaders on RH were under-taken. - IEC and advocacy materials on RH were produced - Information dissemination activities were conducted	UNFPA and LGU of Bambang & Province of Cagayan	on-going
Region II	Featuring in POPBITS (a Regional Population Office 2 Newsletter) "Addressing the Sexual and Reproductive Health Needs of Men Nationwide"	This is an advocacy effort of RPO 2 to disseminate information on Men's Sexual and Reproductive Health.	Regionwide	POPBITS Newsletter featuring Men's Sexual and Reproductive Health published and disseminated to program workers and Influentials		A regular bi-monthly pub tion of RPO
Region III	RH/FP Orientation for the Federation of Tricycle Operators and Drivers Association (FEDTODA)	The project encourages men's involvement in PPMP particularly RH/FP The theme is "Ang TODA Tungo sa	Angeles City	Orientation on RH/FP among the FEDTODA members conducted with 117 participants attending. The highlights of the discussion were focused on the modern FP methods	AED / POPCOM	Start in 2001 Activities are scheduled u mid 2005. W

	by RPO III	Responsableng Pagpapamilya at Maunlad na Pamumuhay."		and Male RH.		awaiting rele of funds fron AED,some groups activities are self-sustainir

Region III	PPMP Orientation re the Importance of Male Involvement on FP/RH	The project encourages men's involvement in PPMP particularly RH/FP.	Malolos, Bulacan	60 males from different sectors were organized, oriented and trained as advocates of RH/FP.	TSAP-AED	Continuing proj. since 2003; ended 2004
Region III	KAP Survey on FP/RH for Men in Uniform	This is an advocacy effort of the Solidarity of Advocates for the Family Enlightenment on FP (SAFE-FP) to help achieve greater social acceptance of FP as a healthy life style.		Meetings among regional multi-sectoral coalition, (i.e. PNP, re inventory of RH practices, capability building , among others). An orientation for Men In Uniform on FP/RH will follow after the survey.		Started early 2003; ending 2004
Region IV	Adolescent Health and Youth Development Project (AHYD)	Conduct of seminars and orientations to youth (ages 15-24 , in-school and out-of-school). Emphasis are on threats that young people face such as drugs, too early sex involvement, pre-marital sex, early marriage and teen-age pregnancy. Also highligted is responsible sexuality and living effectively with peers and parents.	CALARBAZON	Since 2000 about 66.867 young people had been reached. About 40% of them are males.	Local governments & civic groups like Lions	On-going since 2000
Region IV	Pre-marriage Counselling Program (PMC)	-Seminars for couples before they are issued a marriage license. Family planning and responsible parenthood is one of the modules of PMC	CALARBAZON	About 112,813 couples had undergone PMC since 2000, 50% of them are males	LGUs, couples as PMC fee	On-going since 2000
RPO VII	Promoting FP Among Tricycle Operators and Drivers in Metro Cebu	Started in the second quarter of 2004, the project aims to train the officers of tricycle associations and mobilize them as advocates on family planning among the tricylce drivers in Metro Cebu.	Metro Cebu City	Some officers of the association were trained as advocates. These trained officers are the ones to conduct orientations & trainings among the presidents and other officials of the tricylce associations in Metro Cebu. For this year, trainings and orientations will be conducted in Lapu Lapu City.	P100,000 AED	started 2nd quarter of 2004 on-going up to July or August of 2005
RPO VIII	Advocacy for Non-Scalpel Vasectomy (NSV)	The Regional Population Office 8 in coordination with PPO-Leyte and Marie Stopes and Barangay Health Workers formed a team to promote NSV through FP counseling and advocacy among males who are prospective NSV acceptors.	Hilongos, Leyte	FP orientation and counseling conducted which has generated 12 NSV acceptors	-No funding involved except mobi-Lizing BHWs & Pop. Program Workers -Marie Stopes gave 5 kilos of rice to accep-Tors	Completed Jan. 31, 2005 Advocacy on-going up to Dec. 2005
					-Free services from the medi-	

					cal team rice to accep-	
Region XI	Male Reproductive Health Program	This provides adequate information on men's health, improving available health medical services specially for male adolescents, enhancing communication between spouses on the use of contraceptives as well as preventing STDs.	Davao del Norte	Male reproductive centers were installed in all health centers in the province. Medical services for men were made available in the rural health units and district hospitals. Screening for prostatic and testicular cancer is done. Referrals are also made for cases of urological problems.	LGU	Implemented 2 yrs. ago but advocacy activities continuing
Regions IX, XI, XII, and NCR	Capability Building on Reproductive Health for Muslim Religious Leaders (MRL)	This project was undertaken under the 4th and 5th country program of the UNFPA which involved conduct of fora, symposium, orientations and trainings (local and foreign) for Muslim Religious Leaders (MRL) to become advocates of Male RH with the end in view of mainstreaming male RH in Muslim communities.	Maguindanao North Cotabato Sultan Kudarat Davao Zamboanga Manila	-Networking/coordinative mtgs. with and orientations conducted for the Muslim Religious Leaders (MRL) generated support to PPMP & created awareness on male RH -As a result, about 26 MRLs were trained and are now being mobilized as RH/FP advocates.	UNFPA-funded activity	Completed under the 5th Country Program of UNFPA Continuing advocacy/networking with MRL Muslim community
Region XI	Leadership Development in Men's Responsibilities in Gender & Development (MR GAD) Training in coordination with the Health Management Resource Group (HMRG)	A project designed to train policy makers, local chief executives, barangay officials, stakeholders and the media to ensure a wider acceptance among men on the conduct of MR. GAD	Regionwide	-About 40 local gov't executives and barangay officials who are generally male were trained on men's responsibility on RH -Action plans were formulated after the Training -Continuous advocacy and IEC activities among policy makers, local chief executives, barangay officials are being undertaken	P200,000 funded by HMRG P30,000 provided by RPO XI as counterpart	on-going
Region XI	Barangay-based Advocacy on Men's Responsibility on Gender and Development (MR. GAD)	This creates awareness of the concept cept of GAD among barangay officials and leaders through orientation and training among male barangay officials and leaders conducted by the regional population office in collaboration with other agencies	Regionwide	- Radio guesting, press releases & fora with barangay officials/leaders conducted has increased awareness on men's responsibility on GAD - Pilot barangays undertake MR. GAD Trainings	Concerned LGUs/ Barangays	Implemented last year with pilot area. Under regular mandate in coordination with barangays. Continuing-no definite time frame
Region XII	Men in Uniform	The project increases the involvement of military personnel including the police in RH and family planning. Specifically, ductive health, organize different RH forces among them, strengthen the IEC on reproductive health by establishing an RH corner in their respective offices and participation	Cotabato Province	Activities: - Consultative meetings with different military groups conducted - RH issues among military men (low acceptance of family planning, increasing cases of VAW and STIs) were identified. -200 military personnel from different	UNFPA funded	Completed under the 5th Country Program. But it is being continued by RPO XII.

		in various RH activities. The trained military personnel are expected to be models and advocates of RH/FP in their respective camps and are also expected to conduct lectures and counseling among their peers.		military camps/police stations and 1,500 were oriented on RH/FP -Trained personnel conduct IEC activities in their respective camps		
Region XII	Y Factor in Reproductive Health	The Y-factor is an all-male Health/RH advocacy group organized in the province of Maguindanao. It started during the UNFPA 4th Country Program (1996-2000) with the organization of the Health Advocating Ulamas which advocated family planning in the context of Islam. Later, a group of male Barangay Health Workers oriented by the Health Advocating Ulamas on RH were also organized as RH/FP advocates. During the 5th Country Program it expanded into other male groups like the tricycle drivers (RH on Wheels), farmers groups (RH in agriculture) military personnel (men in uniform), indigenous people (male). These groups have become models for the practice of RH as a way of life and have been involved in the advocacy/IEC activities for RH in the province.	Maguindanao Province	-Core of male advocates organized (religious groups, farmers groups, volunteer workers, tricycle drivers, and others) -Trainings and orientations on RH for the members of the different groups were conducted; -Religious caravans and IEC campaigns involving 27 municipalities of Maguindanao were conducted; -Grand Alliance for Reproductive Health was strengthened; - As a result, the no. of FP users in the province increased; -Male BHWs increased from 23 in 1997 to 389 as of 2004; and, -Members of the groups are now covered by PHIC (288 BHWs, 123 farmers and 87 tricycle drivers	UNFPA	Continuing
PROPOSED PROJECTS						
Region VII	Intensifying Community-based Promotion of Family Management (FP/RH) and NSV thru Network of Grassroots Advocates in Cebu City and Minglanilla, Cebu	Nagpakabana Foundation now maintains contact with 72 NSV acceptors who have attended the foundation's medical and FP missions. For this project, Nagpakabana foundation intends to mobilize and organize these NSV acceptors for FP promotion in order to address misconceptions of men on FP methods so that they will support FP practice on their own. A network of satisfied NSV clients will be formed as an NSV club and mobilized for community level FP promotion. They will facilitate the Usapang Maginoong Bisaya session to be held monthly for a total 6 sessions. The project will start with a radio guesting on the 2nd week of	Cebu City and Minglanilla, Cebu		P495,700.00 AED	For 2005 Implementation

		February.				
Region VII	Orientation on Evidence-Based Medicine in Family Planning for Media Partners in Region 8	Media partners in Region 8 (print, broadcast and TV) who generally are males will be invited to this orientation to increase their awareness and knowledge and correct misinformation that have been spread throughout the region with regard to artificial FP methods and also a venue to gain mileage in terms of social acceptability of FP/RH.	Regionwide	30 tri-media persons (mostly male) were invited to this orientation.	AED financial assistance thru the Coalition of FP/RH Advocates in Region 8 (COFPRHA 8)	Orientation was scheduled on held on Feb. 13, 2005 (as pre-valentine rendez-vous with the media partners) but was not pushed through)
Region VIII	FP Advocacy Campaign for Tricycle Drivers	This is a series of FP advocacy campaigns that will be spearheaded by RECONTODA (Region 8) Confederation of Tricycle Operators and Drivers Association in coordination with RPO 8 and other partner agencies	Regionwide	Initial preparations are being done for the small grant program of AED under its TSAP-FP.	AED (small grant of P500,000)	January-December 2005
Region XI	LEAD Project for the LGU	A project designed to address health related issues and concerns by providing health personnel and officials with the management skills and knowledge in implementing health projects and activities.	Davao Norte, Davao City, Compostela Valley	Activities: -Advocacy for the LGUs concerned for inclusion of MR. GAD in their development plans -Lobbying with MSH Lead project for funding of MR. GAD projects and activities	Under negotiation with MSH Lead project	Still a proposal
				Accomplishments: -Inclusion of MR. GAD in the development plans of some municipalities of Compostella Valley -Integration of population issues and concerns were integrated on the work-Plan		

As of February 21, 2005

APPENDIX E

MATRIX OF POPULATION AND RH RELATED BILLS

MATRIX OF POPULATION AND RH RELATED BILLS

Bill Number	Title	Author	Salient Features
SB 1280 **HB 2029**	*An Act Providing for Reproductive Health Care Structures and Appropriating Funds Therefor*	Sen. Rodolfo Biazon Reps. Josefina Joson, Loretta Ann P. Rosales, Liza Maza, Lorna Silverio, J.R Nereus Acosta, Gilbert Remulla, Emilio Macias, Solomon Chungalao, Darlene Antonino-Custodio, Arthur Pingoy	• Establishment and implementation of a Reproductive Health Care Program that shall provide accurate information and education to the people about their reproductive health and rights and offer full access on all safe, affordable and quality reproductive health care and family planning services. • Creation of a Reproductive Health Management Council (RHMC) that shall act as the central advisory, planning and policy-making body for the implementation of all RH care programs and services both in the national and local levels. • The RHMC shall be composed of the secretary of health as the chairperson and the heads of various concerned national agencies, local government units and NGOs. • SB 1280 shall punish any healthcare provider that will withhold information, refuse to extend quality and affordable RH care and services, and fail or cause to fail deliberately the delivery of RH care and services; and any public official who shall prohibit or intentionally restrict legal and medically-safe family planning and reproductive healthcare services. • Violations of this act shall be penalized by imprisonment ranging from one (1) month to six (6) months or imposed a fine of twenty thousand pesos (P20, 000.00) or both such fine and imprisonment at the discretion of the court, provided that if the offender is a public official, s/he shall also be administratively liable.
SB 1546	*An Act Creating a Reproductive Health and Population Management Council for the Implementation of an Integrated Policy on Reproductive Health Relative to Sustainable Human Development and Population Management, and for Other Purposes*	Sen. Panfilo Lacson	• SB 1546 has the same policies and provisions as that of Rep. Edcel Lagman's (HB 16) version in the House of Representatives but contains additional incentives to families having only two children. • Proposed incentives includes automatic enrollment of the children as PhilHealth Card members who shall have preference in the grant of scholarships at the tertiary level in all state colleges and universities.

SB 62	*An Act Protecting the Welfare of the Filipino Family Through the Establishment of a National Family Welfare Commission and for Other Purposes*	Sen. Luisa "Loi" Estrada	Family Welfare Program - Serves as the guiding principle of the National Family Welfare Commission; - Be a main component of every program sponsored by any government agency. - Concerns: 1. Family Planning 2. Health/Maternal and Child Health 3. Information, Education and Communication 4. Women in Development 5. Education 6. Labor and Employment 7. Environment 8 . Migration and urbanization A. National Family Welfare Commission 1. Create a National Family Welfare Commission that shall be constituted by the President as an independent and autonomous body attached to the Office of the president. The Commission shall be replicated at the provincial level. 2. Responsibilities: Make family planning means and services easily accessible at affordable cost and actively promote acceptance of contraceptive practice: a) Expand and improve in an acceptable manner the implementation of family planning and population education programs in schools and throughout the nation; b) Expand youth programs to increase participation in the community activities and help avoid pregnancy before marriage; c) Provide incentives to women who delay pregnancy until 24 years of age; d) Expand population education and family planning counseling efforts to reduce the numbers of high-risk pregnancies; e) Provide education awareness to couples to prevent potential loss of infants; f) Provide training efforts in all areas of maternal and child health care;. g) Provide breastfeeding information campaign h) Improve the demographic knowledge base and utilize in economic planning i) Review action plan, monitor and evaluate the implementation of the national population policy.
SB # 74	*An Act Reducing the Income Tax Rates of Individual Taxpayers, and Granting the Payment Exemption to Certain Minimum Wage Earners* *"TAX PAYMENT EXEMPTION ACT"*	Sen. Luisa "Loi" Ejercito Estrada	• This proposed measure seeks to pursue equitable tax burden distributions and provide tax relief to the disadvantaged sector, who suffers most amidst our economic turmoil. • Specifically, it seeks to reduce the income tax rates of individual taxpayers and grant income tax payment exemption to certain minimum wage earners. • Important feature s related to the "Two Child Policy" Section 35, Letter B of this Bill aims to: 1) Increase the additional exemption for dependents from P8,000 to P15,000 for each dependent not exceeding four (4);

			2) Provided, however, that on the third (3rd) year of implementation, the additional exemption shall be allowed for each dependent not exceeding three (3), 3) On the fourth (4th) year of implementation, additional exemption shall be allowed for each dependent not exceeding two (2) Other features of the Bill: • Reduce the taxable income tax rate to fifty percent; • Increase the tax exemption rate
HB 1808 **SB 1281**	*An Act Establishing an Integrated Population and Development Policy, Strengthening its Implementing Mechanism and for other purposes* *Integrated Population and Development Act of 2002*	Reps. J.R. Nereus Acosta, Gilbert Remulla, Darlene Antonino-Custodio Sen Rodolfo Biazon	• To create an enabling environment where population, development and environment-sensitive policies and programs are inextricably-linked instruments for the realization of healthy, educated, and empowered people; • To fully integrate population concerns into development strategies, planning, implementation of programs and resource mobilization and allocation at all levels of government; • To ensure equity in development, reduce the unreasonable use and consumption of resources that affect the environment, and provide social safety nets for vulnerable groups; • To enable individuals and parents to achieve their desired family size in the context of responsible parenthood and sustainable development and in accordance with their personal, moral, religious and cultural beliefs and values; • To foster a more balanced spatial distribution of the population by promoting in an integrated manner the equitable and ecologically sustainable development of major sending and receiving areas; • To promote an effective partnership between and among the national government and the local government units, the private sector and the civil society, in the design, implementation, coordination, monitoring and evaluation of programs relating to population, development and environment; • To assess population trends in order to achieve eventual population stabilization within the context of social and economic development and respect for human rights
HB 2029	*An Act Providing For Reproductive Health Care Structures And Appropriating Funds Therefor* *The Reproductive Health Care Act*	Reps. Josefina Joson, Loretta Ann P. Rosales, Liza Maza, Lorna Silverio, J.R Nereus Acosta, Gilbert Remulla, Emilio Macias, Solomon Chungalao, Darlene Antonino-Custodio, Arthur Pingoy	**SAME AS SB 1280**
HB 16	*An Act Creating a Reproductive Health and Population*	Rep. Edcel Lagman	• Creation of a Reproductive Health and Population Council with Secretary of Health and Director-General of NEDA as co-chairpersons and with LGU and NGO representation;

	Management Council for the Implementation of an Integrated Policy on Reproductive Health Relative to Sustainable Human Development and Population Management, and for Other Purposes *The Reproductive Health Care Act of 2004*		• Active participation of the LGUs in the implementation of the measure. • Provision of mobile health care services in every Congressional District; the operation of which shall be funded from the Priority Development Assistance Fund (PDAF) of each Congressional District; • Mandatory Reproductive health and Sexuality Education from Grade five to fourth year high school with a common curriculum for both public and private schools • Capability building for barangay health workers; • Tax incentives for manufacturers and importers of reproductive health commodities; • Employers' responsibilities like non-discrimination against women and inclusion of free delivery of reproductive health care services which shall be incorporated in all Collective Bargaining Agreements; • Private practitioners' assistance to indigent patients; • Tax deductible donations to reproductive health care program

APPENDIX F

LIST OF IEC/BCC MATERIALS FOR MALE PARTICIPATION IN FAMILY PLANNING (FEBRUARY 2005)

LIST OF IEC/BCC MATERIALS FOR MALE PARTICIPATION IN FAMILY PLANNING (FEBRUARY 2005)

A. FPOP

Flyers/stickers (each sticker has a caricature of a man, either with a child or his family)

1. Sa *responsableng ama, pagpapamilya'y mahalaga*.(To a responsible father, the family is important);

2. Ama ng tahanan: Ang bawat ina ay may sariling karapatan. Siya ay mahalin at igalang.(*Father of the home: each mother has her own personal rights. She should be loved and respected*)

3. *Isa, dalawa, tatlo, kahit na apat, basta nasa tamang agwat.(One, two, three, even four, as long as the spacing is ok)*

4. *Maginhawa ang pag-aalaga ng anak sa magulang na magkabalikat (* Child care is easy if the parents work together.

AdvoKit

Orientation Paper: Ang Maginoong Pinoy (the Filipino Gentleman)

For male involvement month (June).

DKT

Flyers/stickers

1. *Sa Trust Family Program Kasangga mo ang LANGIT! Dito ka sa pagpaplano ng pamilya na (* In the Trust Family Program, you join heaven. You should use this to plan your family*) Reliable (maasahan), Affordable (Abot-kaya), Convenient (Kumbinyente).* Note Langit here is the name of the radio announcer. Langit means heaven.

2. *Type na type kita kasi (* You are my type because) *you're Totally Responsible, Understanding, Sensitive & Trustworthy.*

3. *Driver na maswerte, lapitin ng babae (*Lucky jeepney driver, attractive to women*).*

4. *Huwag maging hunghang maging wow-hunk* (Do not be weak/soft be wow—hunk)

5. *Huwag pasok ng pasok (* Do not just enter)

6. Life and love…DEPO TRUST Provides the Convenience of a Long-Lasting Contraceptive;

7. Ang DMPA: Depo Medroxyprogesterone Acetate

8. Trust Classic. *Iba ka tsong*.(You're different, man.)

9. Get into it. The intelligent way! Using frenzy condoms properly.
   Frenzy "The Party Condoms"

CD: DKT Historical Reel –TV ads

REACHOUT FOUNDATION INTERNATIONAL

CD for radio ads (in four local languages:Tagalog)
Ilocano, Cebuano, and Ilonggo)—Modern Methods of Contraception Phases 1-3,
Phases 4-5 Radio 30's

VHS—RH and STD: Media Campaign for TV(16 minutes)

Posters

1. *Ayokong magka-STD, AIDS at makadisgrasya…kaya inalam ko ang RH, ParaLuminaw ang iyong pananaw tungkol sa STD, AIDS at Family Planning, magpunta sa health enter ngayon.* **(**I do not want to have STD, AIDS and accidentally impregnate women…so I earned about RH. So that you will understand STD, AIDS and Family Planning, go to the health center now).

2. *Alamin Ang hanap naming sa lalake. Alam mo ba ang ginagawa mo? Importante yan pagdating sa sex at reproductive health kaya samahan na si misis pagpunta sa health center. Pag may kaalaman, mas liligaya ang buhay ng mag-asawa Alamin sa health center.*(Know what we are looking for in men. Do you know what you are doing? It is important when it comes to sex and reproductive health so accompany your wife to the health center. If knowledgeable, the couple is happier. Get the information from the health center.)

Comic book

Macho RH Comics Komiks ukol sa reproductive health ng kalalakihan 5 istoryang hahamon sa inyong isip, puso at pagpapasya. (Macho RH Comic. book about reproductive health of men 5 stories that will challenge your mind, heart and decision).

TSAP-FP

Flyers

1. *Ang Katotohanan Tungkol sa FAMILY PLANNING*. (The truth about family planning);

2. National Fatwah on RH and FP;

3. Orientation materials on family planning for Muslim Religious Leaders (August 2004) Cotabato City, Philippines. A draft.

ENGENDERHEALTH WITH USAID & DOH

Poster

Sabi no Dr. Jondi Flavier, "No problem, pare". Eight minutes lang, tapos na. Band aid lang ang kailangan. I had my usual meetings pagkatapos. Walang sakit buong araw. (Dr. Jondi Flavier said: "No problem, man". It takes only eight minutes to finish. Only band aid is needed. I had my usual meetings after. No pain the whole day.) And the best results—my 2 kids are well provided for. Alagang-alaga (they are well take care of.) My wife is even happier. Our sexlife…bravo! No Scalpel Vasectomy. Life is easy.

Flyer

No Scalpel Vasectomy (NSV) Ilocano.

PHILIPPINE RURAL RECONSTRUCTION MOVEMENT (PRRM)

Monograph/books

"Kwentong KaMACHOhan: Isang Kit tungkol sa Male Reproductive Health" 2004.
(Stories about machismo: A kit about male reproductive health).

"Family Planning Made Easy: The Agricultural Approach to Family Planning Information, Education, & Communication " by Dr. Juan Flavier, 2004.

UNFPA

Monograph

"Kaakbay: Building Better Lives Together, Success Stories in Reproductive Health", 5th UNFPA Country Programme.

POPULATION SERVICES PILIPINAS, INC.

Monograph

"Male Call: Enlightened men Empowered Citizens" (2000)

PATH FOUNDATION PHILIPPINES, INC.

Monograph

The Rewards of Innovation: A Review of the Successful Piloting of
the Integrated Population and Coastal Resource Management (IPOPCORM) Project

Flyer

Tol' Para sa iyo 'to. (Brother, this is for you).

Compact Disk

Training Curriculum for Male Peer Educators

Comic Book

Kaakbay Komiks (Arm in arm comic book). Vols. 1 & 2

PHILIPPINE FAMILY PLANNING PROGRAM WITH UNFPA

Flyer

Vasectomy para sa lalaki. Permanente mga pamaagi sa mga lalaki; alang sa managti-ayong dili na gusto pang manganak (1996). At the back, the box states: *Vasectomy pamaagi na permanent sa mut palaki sa kahimsog ninyong managti-ayon ug sa tibook pamilya. "Alang sa dugang kasayuran mokunsulta sa inyong kinadul-an nga FP clinic. (*Vasectomy for men. Permanent method for men, for couples who do not want to have children. Vasectomy permanent method method for the prosperity of the couple and the whole family).

DAVAO DEL NORTE PROVINCIAL HEALTH OFFICE

Flyers (for male reproductive health clinics)

1. "Real men are responsible, and they take responsibility for their actions, the well-being of the children, the happiness of their families. It started with me…it will end with me…"

2. Vasectomy (in Cebuano)

3. Condom (kondom, in Cebuano)

IRH

Flyer (on SDM)

1. *Para walang kaba…mag-CycleBeads na! Bago, simple Natural na Family Planning*

(So that there is no fear/worry…use-Cycle Beads, simple Natural Family Planning).

2. Standard Days Method Calendar How to Use Cycle Beads

FRIENDLYCARE FOUNDATION, INC.

A well-planned family is a happy family. NO-SCALPEL VASECTOMY

A well-planned family is a happy family. BILATERAL TUBAL LIGATION

SAVE THE CHILDREN

Monograph

Walking the Extra Mile (2003)

Training modules

1. PESCO-DEV Trainers for Family Planning. Family Planning: Action Session Guide; Family Planning: Session Reference (for couples, 2 volumes).

2. Facilitators' Guide: An orientation seminar on adolescent reproductive and sexual health

TUCP /UNFPA

Posters (from the power point presentation: Mobilizing Men for Involvement in Reproductive Health in the Workplace)

MEN: Key Partners in Reproductive Health. *Ang Reproductive Health ay hindi lamang para sa kababaihan. Malaki at Mahalaga ang Papel na Dapat Gampanan ng Kalalakihan. Mga Kalalakihan, Manggagawa man o Hindi. Sa Hamon ng Reproductive Health, Huwag Tumanggi.* (Reproductive Health is not only for women., Men have a big and important role to play. Men, whether workers or not. Do not refuse the challenge of Reproductive Health.):

1. *Hindi sa bigote… hindi sa bote… lalong hindi sa pambababae nasusukat ang pagkalalaki. Ito ang tunay na lalaki RESPONSIBLE (sa pagawaan man o sa tahanan.)* (It is not from the moustache…not from a bottle of alcohol…especially not from womanizing is a manhood measured. This is a real man Responsible (at the factory or at home).

2. Join the search for MAN of the NEW CENTURY 2000 Qualifications. Responsible citizen, responsible worker, responsible husband, responsible father.

APPENDIX G

METHODOLOGY AND DOCUMENTATION FOR QUALITATIVE DATA COLLECTION

METHODOLOGY AND DOCUMENTATION FOR QUALITATIVE DATA COLLECTION

BRIEF FRAMEWORK FOR FGDs

I. GENERAL FRAMEWORK CONSENSUS INFORMATION ON FGDs

Focus group discussions (FGDs) can be defined by describing their six characteristics or features. "These characteristics relate to the ingredients of a focus group: 1) people, 2) assembled in a series of groups, 3) which possess certain common characteristics, and 4) provide data 5) of a qualitative nature 6) in a focused discussion." (Krueger, 1994).

It is important that the groups are not too big, and that they comprise people with a certain degree of homogeneity in relation to the topic under discussion.

Each session will be started by informing participants about the purpose of the group and by assuring them confidentiality. Sessions will be chaired by a moderator and everyone will have equal chance of participation. Discussions will be guided in a semi- structured manner around a framework of specific issue areas. However, the participants should be free to come up with a somewhat wider menu of relevant topics. The groups will be made up of between four to ten participants.

II. REFRESHMENTS AND/OR REMUNERATION .

We are not permitted to provide cash to FGD participants. We can provide refreshments, lunch, and/or small gifts (such as food items or snacks). We much have receipts for the purchase of refreshments and the small gifts. Please send me an estimate of the costs for these costs ASAP so I can send it to POPTECH in DC.

III. SUGGESTED FRAMEWORK FOR SEMI–STRUCTURED FOCUS GROUPS (Adapted from Bailey et al. 2002)

1. Initial Welcome

Welcome. Thank you for coming and agreeing to assist us with our research project. My name is ***Moderator's Name***, and my colleague here is ***Note taker's Name***. We are members of a team that is working on the issue of involving men in family planning. In this part of this project, we are talking with men and women in various communities to learn more about what people think about men's role in family planning, both to help their wives use a method and to use methods of FP themselves. We are interested in learning about your experiences, opinions, and beliefs about how men can be involved in FP. The information you give us can help with future efforts to improve FP services.

2. Explanation of Process and Logistics

The section will explain basic nature of focus groups, importance of confidentiality, no "right" answers, reason for the research/the group today, why using tape player, can leave group or have tape turned off at any point, etc.

This group discussion will last approximately 90 minutes. As the moderator of the discussion, my job is to make sure that we stick to the topic at hand and that everyone gets a chance to participate in the discussion. I will ask you a series of questions to which you should feel free to respond or not. The questions concern the attitudes of people in your community about men and FP. As you will see, there are no right or wrong answers to these questions. We are asking them of you because we value your opinions and knowledge about these topics. You are the experts and we are here to learn from you.

3. Use of Tape Recorder

Because we value your opinions, we would like to tape-record the discussion so that we can go back over your responses to our questions. If this recording is a problem let us know and we will simply write your responses on paper. [***Notetaker's Name***] will be taking notes to help us remember what you said during the discussion.

4. Discomfort

The risks to you of participating in this discussion are minimal. Some of the questions I ask may make you uncomfortable. You are not required to respond to any particular question, and if at any time during the discussion you would like to stop, just tell me, and you may end the discussion.

5. Benefits

Your participation in this group discussion may benefit other people in this community and around the Philippines in the future. We are able to offer you some snacks during the discussion (and a small gift to show our appreciation), but other than that there are no direct benefits to you for participating. At the end of the discussion if you have questions about anything we have discussed, we can take some time to discuss them or, if you prefer, I can make an appointment with another qualified person to speak with you.

6. Confidentiality

You should be assured that we consider this discussion to be confidential. Your response will be heard or read by only a handful of people working at this project. The tape and written documents recording your responses will be kept in a safe place, and your name will never be used when reporting the results of the study. I will ask you your name just to make the discussion easier, but we will not retain a record of your name. If you would like, you can use a fictitious name.

7. Begin Tape Recording

Now, if you have no objections, I will turn on the tape recorder and we can get started.

8. Introduction Participants

Note down participants name, sex, and age etc.

I'd like to start by asking you each to introduce yourselves. Please tell us your name or the name you would like us to use during this discussion and, if you would like, your age, what work you do, and the level to which you studied in school. This is the only time I'll ask each of you to speak in order. After introducing yourselves, please feel free to speak whenever you have something to say, but also please listen to others in the group.

9. Test Volume of Tape Recorder

Test volume level on tape so they can hear if they're speaking loud enough.

10. Begin FGD Guide Questions

MALE PARTICIPATION ASSESSMENT:
QUALITATIVE METHODS FOR THE FIELD

1. The male involvement assessment study will utilize two main qualitative methods in the field—key informant interview and focus group discussion.

2. The key informants will include (a) officials/staff of national agencies and Congress, (b) health NGOs, (c) local government officials and health officers, (d) key male leaders/beneficiaries of programs on MP in FP, (e) religious leaders.

3. The focus group respondents are male leaders/recipients of specific programs , e.g., Muslim Religious Leaders (MRLs) of ARMM, NSV clients.

4. Research instrument— one interview guide for KI interviews and one for focus groups.

Suggested topics and questions for the KI interviews.
For policy makers:

1. Why is there a need for male participation in FP?
2. What does male participation in FP mean? What are its components?
3. Are there laws and policies that are supportive of MP in FP? What are these? What are the models/frameworks of these legislations?
4. What are the positive effects of these laws/policies in involving men in FP?
5. What are the obstacles in developing and implementing policies on male involvement in FP?
6. How are these obstacles met?
7. What are your suggestions to ensure that men participate in FP?
8. What are the prospects of institutionalizing male participation in FP?

For program/project implementers:

1. Organizational/program/project profile—objectives, activities, structure including membership, and funding sources especially for MP in FP
2. History of involving men in FP
3. Basis of formulating FP programs involving men –is this derived from international, national or local policies? Is this donor driven? Is this the organization's own initiative?
4. Model or framework of MP in FP—does this focus on men and women's roles and relationship?
5. Major outcomes/accomplishments
6. Difficulties encountered
7. Strategies to overcome difficulties
8. Prospects/future plans to institutionalize men's involvement in FP
9. Are there technical reports or articles written about this program?
10. Has this experience been presented in conferences and workshops? (Ask for copies for program reports/papers)

DRAFT VASECTOMY (NSV) FGD GUIDE
Draft for review and comment only: Not for distribution
2/11/2005

These are draft questions for couples who rely on vasectomy for family planning.

Thank you for coming in to this meeting today. We appreciate your having opted to undergo vasectomy. You are a very special group of men and women for having made this important decision. Today we would like to discuss your experience with vasectomy.

1. How did you learn about vasectomy?

2. What made you decide to have a vasectomy? (Probe for communication ,including counseling, services, and policies (allow for other social and cultural issues).

3. How did you decide: by yourself, in consultation with wife, and or in consultation with others?

4. How long did it take you to decide? (Probe for reasons for quick versus a delayed decision.)

5. What were obstacles to your getting a vas? (Probe for issues related to communication, services, policies, and social cultural issues (like machismo and fears of lost fertility etc).

6. Let's talk about your experience with the procedure. What went well? Were there any problems?

7. Let's talk about the recovery process. What went well? Were there any problems?

8. How has vas affected you, your relationship with your wife, and relationships with your friends and family?

9. Based on your experience with vasectomy, what are things that can be done to encourage other men to adopt vasectomy? (Probe for ways to encourage vasectomy via communication, services, and policies.)

10. Why do you think you were willing to do vasectomy when so many men are not?

11. If you were to promote vasectomy to other men and women, what would you suggest? (Probe for ideas oriented to men as well as to women).

TAGALOG VERSION OF NSV FGD GUIDE

Introduce yourself.

Thank the participants.

State the aim and objective of the FGD: pag-uusapan natin ngayon ang mga karanasan at pananaw niyo tungkol sa vasectomy para malaman natin kung paano mapalago ang paggamit nito ng iba pang mga kalalakihan.
Length of FGD and the need for everyone to participate, and that there is no right or wrong answer.

Clarify confidentiality, tape recording

1. Paano niyo nalaman ang tungkol sa vasectomy?
2. Bakit kayo nag-desisyon na magpa-vasectomy? (Probe for communication, including counseling, services, and policies (allow for other social and cultural issues).
3. Paano ka nagdesisyon: sarili mo lang? kinunsulta mo ang iyong asawa? O kinunsulta mo ang ibang tao (sinu-sino ang mga ito?)
4. Gaano katagal bago ka nagdesisyon? (Probe for reasons for quick versus delayed decision).
5. Kung natagalan o nabilisan ang iyong pagpapa-vasectomy, anu-ano ang mga dahilan? (Probe for issues related to communication, services, policies, and socio-cultural issues (like machismo and fears of lost of fertility).
6. Pag-usapan natin ang iyong karanasan sa procedure ng pagpapa-vasectomy. Nagkaroon ba kayo ng problema o wala?
7. Pag-usapan naman natin ang iyong paggaling. Nagkaroon ba kayo ng problema o wala?
8. Paano nakaapekto ang iyong pagpapa-vasectomy sa iyo, sa relasyon mo sa iyong asawa, and relasyon mo sa iyong mga kaibigan at pamilya?
9. Base sa iyong karanasan sa vasectomy, anu-ano ang puwedeng gawin para mahikayat ang ibang lalake na magpa-vasectomy? (Probe for ways to encourage vasectomy via communication, services, and policies).
10. Sa palagay mo, bakit pumayag kang magpavasectomy samantalang ang nakakaraming lalake ay ayaw?
11. Kung ipro-promote mo ang vasectomy sa ibang mga lalake at babae, ano ang iyong mungkahi?

DRAFT MRL FGD GUIDE
Draft for review and comments only: Not for distribution
February 11, 2005

These are draft questions for FGDs with male and female MRLs.

Today we would like to talk about the involvement of men in FP, either as
1. Facilitators, helping their wives to use a method of FP (for example, the wife uses pills, IUD, injectables, NFP or female sterilization).
2. Users of FP themselves (for example, when men adopt a method such as the condom, vasectomy, NFP, calendar rhythm, standard days method (SDM) or withdrawal).

Before we begin our discussion, do you have any questions about what I mean by the involvement of men in FP? (Allow a pause to be sure people have a chance to ask for clarification).

I would now like to ask you some questions….

1. Are there difficulties for men to be involved in FP, either to:
   - Help their wives use an FP method ; or
   - Use a FP method themselves? Probe to seek responses to both of these two alternatives.

2. What are the difficulties men encounter in participating in FP, either to:
   - support their wives use of FP;
   - use a method themselves? Probe to seek responses to both of these alternatives. For each of these two alternatives probe for difficulties related to communication (for example, lack of information in the media), services (for example, unavailability of FP methods), and policies (for example, laws or regulations on FP that ignore men).

3. What do you suggest to solve these difficulties? Probe for both: A). difficulties men have in supporting their wives use of FP); and B) difficulties men have in the use of a method themselves. For each of these two alternatives probe for difficulties related to communication (lack of information in the media), services (availability of FP methods), and policies (laws or regulations on FP).

4. What will make men support their wives use of FP?
   - Probe for ways to communicate with men to support their wives (examples include: radio/TV/peer groups/venues to communicate with men (examples include: friendly reception to men at a FP clinic, office hours convenient).
   - Probe for ways to provide services for men to support their wives (for example, convenient office hours, friendly reception for men, FP programs for men in the workplace).
   - Probe for policies or laws that help involve men support their wives (examples include: fatwa, paternity leave).

5. What will make men use a method of FP?

- Probe for ways to communicate with men (for example, radio/TV/peer groups/venues to communicate with men).
- Probe for ways to provide services for men (for example, services at the workplace, services after work hours).
- Probe for policies or laws that help involve men (for example, have insurance cover cost of vasectomy or condoms, etc.).
- Do we need laws to help men be involved in FP?

6. If the couple has reached their fertility goals (the couple has the number of children they want), should they adopt a permanent method (female sterilization or male sterilization)? If so, who should adopt the permanent method: the man or the woman?

DRAFT SDM FGD Guide
Draft for review and comment only: Not for distribution
February 11, 2005

These are draft questions for FGDs with male and female respondents who are current users of the Standard Days Method (SDM) of family planning (FP).

Today we would like to talk about the involvement of men in the SDM of FP, either as

- Facilitators, helping their wives to use the SDM method of FP, or
- Being directly involved in the SDM of FP themselves (for example when men adopt the SDM, they may opt to use condoms during the fertile period of the month).

Before we begin our discussion, do you have any questions about what I mean by the involvement of men in the SDM of FP? [Allow a pause to be sure people have a chance to ask for clarification.]

6. Are there difficulties for men to be involved in the use of SDM? Either to: a) support their wives use of SDM; or b) to use a back-up method themselves during the fertile part of the cycle? Seek simple "yes" or "no" responses to both alternatives a and b.

7. What are the difficulties men encounter in participating in SDM? Seek responses to both alternatives a and b. For the first alternative, men supporting the wife's use of SDM:

   A. Probe for difficulties related to communications with men to support their wives (examples include: media influence, lack of role models for men).
   B. Probe for difficulties related to services for men (for example lack of FP programs for men after work hours or in the workplace).
   C. Probe for difficulties related policies or laws (examples include traditional emphasis on FP as a female responsibility at FP clinics). For the second alternative of helping men use a back-up method themselves during the fertile part of the cycle when using SDM.
   D. Probe for difficulties related to communication:(examples include: media influence for men to be macho on radio/TV or unfriendly reception to men at a FP clinic).
   E. Probe for difficulties to provide services for men (lack of services at the workplace, services after work hours),
      a. Probe for difficulties related to policies or laws that help involve men (insurance does not cover cost of condoms, etc.).
      b. Do we need laws to help men be involved in the SDM FP?

   F. What do you suggest to solve these difficulties? Probe for solutions to the difficulties cited above for both alternative a and b.

   G. What will make men support their wives use of SDM of FP? Probe for ways to communicate with men to support their wives (radio/TV/peer groups/venues to communicate with men). Probe for ways to provide services for men to support their wives (work based programs). Probe for policies or laws that help involve men support their wives (fatwa, paternity leave).

H. What will make men use condoms or withdrawal as a back-up method of FP during the fertile time of the month with the SDM? Probe for ways to communicate with men (venues to communicate with men). Probe for ways to provide services for men (work based or after hours programs). Probe for policies or laws that help involve men (PhilHealth coverage etc.).

I. If the couple has reached their fertility goals, should they adopt a permanent method? If so, who: the man or the woman?

APPENDIX H

RESULTS FROM FGDS AND IN–DEPTH INTERVIEWS

RESULTS FROM FGDS AND IN–DEPTH INTERVIEWS

(Documentation of Two FGDs and In-Depth Interviews with SDM Clients, MRLS, MIUS and Muslim Women (Dr. Pilar Jimenez)

Item	MRLs	Women	MIU	SDM
1. Difficulties of men a. Support wives b. Use FP Method	In Islam, couples are obliged to plan their family but men encounter difficulties in supporting the wives to use FP method, and in using an FP method themselves. Yes to a & b	Yes Yes	Yes Yes	In general, SDM users have no difficulty using the method: 1) It is easy to understand and use; they know when to and not to have sex.. 2) They do not find it difficult to abstain during the fertile days. 3) SDM has no side effects. 4) the major from Malaybalay is supportive of SDM. 5) Those who dropped out were unable to observe the requirements of the fertile period or have not met the criteria for using the method
2. What are these difficulties a. Support wives b. Use FP method	For support of wives and use of methods themselves: a) Poor men can't buy contraceptives for wives and condoms for themselves; b) Lack of correct information about FP; c) Radio FP messages short incomplete; d) FP is birth control because of 2-3 children promotion made by gov't ; e)Belief that countries that produce modern methods want to reduce Muslim population in the country; f) Rural areas have less access to FP services and commodities;	Ideal in Kor'an: It is forbidden for the wife to have another pregnancy within two years after delivery, she is obliged to breastfeed infant. a) The above ideal is not followed among many clients; women get pregnant within the haram period. b) Spacing is urged by in-laws and herbs and tree roots are used to prevent pregnancy; men are involved in the collection and preparation of these herbs. c)Introduction of modern FP methods—not readily accepted by men because their mind set is attuned	Support of wives' communication: a) lack of education and information; b) misconceptions that men can not get involved in FP as they perceived that FP is a female concern; they also perceived that FP is equated to abortion particularly the use of pills, condom—source of this misconception is the Catholic Church; c) baka mawala ang pagka-macho—daghan anak, dili baog, dili daut ang picture tube; d) kung mag BTL, magselos ang asawa kay baka mag –sideline kung nasa kampo sila. FP services: they are maulaw, mataha, mahilasan	During fertile days, the couple usually abstain by turning their backs when sleeping. Husband entertains himself by drinking alcohol with neighbors and returning home ready to sleep; watch TV shows. They feel at ease with their partners by embracing each other but they abstain from sex or using condoms or else they are not considered SDM users anymore. What changes in their lives have they noticed after using SDM? The major changes are: The couple seems to care more for each other. Their income is better because they do not have to feed and attend to the needs of many children and send them to school. The women are less stressed because they are confident that they would

	g) Few men know about the national fatwa which states that FP is birth spacing and is acceptable in Islam—dissemination to various provinces is new and have not yet reached many men in communities in the ARMM; h) Men who are informed about the fatwa are still at the awareness level about FP; i) Modern methods are not yet widely used; husbands still use withdrawal as this is method endorsed by its prophet for child spacing.	to usage of herbs and roots. d) Some men including some ulamas are saying up to now that pills and other modern methods are from Christian country and the Muslims are being forced to reduce its population in the country; they believe that the 2-3 children policy that the government promotes is not acceptable to Muslims because of the foregoing reason. e) With the entry of UNFPA project, they noticed increased CPR among Marawi and Cotabato City women—the majority (80 percent) of women use modern methods especially pills and depo without telling husbands; when discovered by husbands, women talk to them about their multiple burden, their economic situation,, her health and difficulty in bearing many children. f) Men reportedly do not react and object because the women keep returning to the health centers for contraceptives. g) Men rarely use	to get information because the health workers are mostly women; they were pleased that it was Dr. Catague who explained RH because nawala ang ilang ulaw, kay derecho ang pag-istorya ni Dr. Catague; he uses correct terms, maskin murag bastos pero way pasumbingay. Policies: Church laws, especially devout Catholics among the PNP are making it difficult for men to encourage wives to use FP methods. For the men themselves: Communication: Wa sila naanad, their mind set is that FP is for women; kung mag-estorya ang mga lalaki, ang pangutana, unsay gamit nato—pills; unya ang pills are for women. Services: Health providers are mostly women even in hospitals; when MIU go to health center to ask for condoms—they are heckled by HPs—basi pang-chicks or to use for other women. Policies—the church laws, the bottom line is politics—among church goers, especially those	not get pregnant anymore. They and their husbands start dating again. They do not quarrel anymore; there is better understanding between the partners because they know when they are safe and unsafe from pregnancy. Suggestions: Men will use SDM because the method is explained together with their wives; SDM must be introduced to couples than to the woman or man alone. In general, the local officials are supportive of SDM. In Malaybalay, the health facilities have enough necklaces and calendars. The health facility of Valencia, however, do not have necklaces anymore. It was learned from the CHO in Valencia that she no longer promoted SDM because she was confused with the differences in fertile days between the "Ligtas Buntis" campaign and SDM. So she dropped the SDM until this is resolved by the DOH. The Valencia SDM motivators have ran out of necklaces which were provided earlier by IRH and the matching grant. They have now resorted to using home calendars to demonstrate the SDM. Their personally-owned necklaces serve as demonstration tool during the training.

		condoms because they are embarrassed to procure these from the health centers; the health facilities are often operated by women and they are embarrassed to ask women for condoms. h) Women reportedly do not like condoms and withdrawal because these are not sexually satisfying; this is particularly true for young married couples; i) Hard-to-reach communities particularly in critical areas in terms of security have many illiterate men and women and midwives visit them only around once or twice a month. j) Although ulama is an important person whom men respect and listen, the former utilizes IEC materials that do not specifically address men and FP.	who want to run for politics, mahadlok kay basig way moboto sa ila kay there are karatolas which are anti-RH; mao bitaw napit mapildi si Senator Biazon kay he was was campaigning for RH The Catholic Church uses emotion, too biblical, not knowing the effects of having many children on people's lives—that it is not easy to send them to school, to meet their basic needs; that when there are few children, the economic conditions improve, that this reduces diseases, poverty, the number of street children, thieves, prostitution, etc. and more young people will turn to the left-- if these problems exist, they will redound to more problems for the military, the police. The government is really attending to development, to the welfare of many people. They lament the fact that the Catholic Church tends to side with the left rather with them who are protecting the general public.	

3. Suggestions to solve difficulties	Communication— a) Develop TV and radio programs where the subjects are Muslims. Message must state that FP is allowed in Islam and where FP can be accessed. b). Hold house-to-house campaign comprising of medical and MRLs to explain the religious and health aspects of FP in the fatwa; c). Ulama can talk about FP during pre and marriage ceremonies particularly the role of husband in FP to audience and to the couple; d). Have 24-hour/7 days health centers beside barangay offices to provide services to men and women—these health facilities must have male midwives/BHWs to enable men to approach them for FP services and commodities; e). Sustain the core team of trainors comprising of MRLs and medical doctors provide the orientation to provincial MRLs/mufti about fatwa and FP methods; f). Trained provincial MRLs will echo/orient	a) Men should undergo a series of orientation seminars with the guidance of an ulama and health providers; b) Although the fatwa helps the ulama in preaching that FP is allowed in Islam because it focuses on spacing rather than birth control—the document does not clearly spell out how men should be involved; there should be a document that describes how men should participate in FP. These guidelines should be prepared to clearly illustrate how men should be involved in FP instead of leaving the initiative to men; c) More radio programs in the local language encouraging men to participate in FP and use a FP method; d) More print media such as flyer and posters in the local language must be made available; these should feature Muslim talent; e) Have male health providers and BHWs in the health centers/stations so that men would be able to ask for condoms and other	Help wives to use FP method and men to use FP method: 1) Communication: a) There should be more information, education campaign such as: a) Pulong-pulong during their barangay visitation which serves as an occasion to discuss with barangay tanod, local leaders, residents who are mostly men; they provide leaflets obtained from IPHO regarding FP methods; b).Posters with MIU with slogans about male showing that they are introducing RH/FP in barangay to dispel the widely shared notion that MIU are ma-tsiks and to improve their image as responsible men; c) Radio program such as the Pulisya ng Katawhan—should include discussion on FP, that the police is helping the wife in FP. The TV program/advertisement with MIU leaders as the models. 2) Services: There should be male HPs and BHWs	

	local ulama who in turn can orient men and women about FP in their respective communities; g). Encourage MRLs to link with COs/CDs who will talk to communities particularly men about FP; h). Orient adolescent male and female students about fatwa and FP; i) Encourage ulama to talk about fatwa and men's role in FP during Friday prayers which are attened mostly by men; j) Translate fatwa into local Muslim languages in the ARMM; k) Offer FP services to Muslim men in the workplaces particularly in places with factories; l) Make sure that DOH provides necessary FP services and commodities in the health facilities at the urban and rural areas.	FP services with ease and comfort; h) Conduct baseline study about why Muslim men do not want to use or be seen at health centers; i) The fatwa is supportive of women but it needs to focus on the need for men to use FP methods themselves. This should be clearly emphasized in the dissemination of the fatwa in various situations.	and men's desk for FP similar to women's desk for VAWC so that dili sila kantiyawan when they ask for condoms, kay makasabot sila better than women HPs (3) Policy: Advocate RH bill so that heads of Church can be informed what RH and FP really mean; that these do not mean abortion, that they can be given the scientific explanation about FP methods. They said that the pari and madri do not have experience manganak and experience is the best teacher; sige lang sila yawyaw. Dapat tutukan mas lalo ang RH to include men lay workers para makasabot giyud na silag mayo. They added that something must be done about FP kay the land is not increasing compared to our population. How can the land sustain a large number of people?	
4. What will make men support wives a. Communication b. Services c. Policies/laws	Same as above	Same as above	Same as above	

5. What will make men support wives a. Ways to communicate with men b. Services c. Policies d. Laws to help men	Same as above	Same as above	Same as above	
6. Permanent method	No to permanent method because of divorce and polygamy. Men and women may want to have more children after they divorce; men who want to take two or more wives may want to have children with these women. BTL allowed only when the life of the woman is at risk.	BTL is allowed to high risk women even if they have only one. child as long as this is recommended by the medical doctor; men will not submit to vasectomy because they view this as castration—"parang karabaw na kinapon, buting pang mamatay na, useless na."	Men—NSV for the men because it is safer, faster compared to BTL which they learned as risky.	They will not use a permanent method; they intend to continue using the method until the women are menopausal because they have no problem with it; there are no side effects;

DOCUMENTATION OF FOCUS GROUP DISCUSSION IN BARANGAY STA. CRUZ, MUNICIPALITY OF BAGABAG, NUEVA VIZCAYA, 14 FEBRUARY 2005, 310-4PM

PARTICIPANTS

Three couples (two couples, in their 40s, with achieved fertility goal of one or two children were using withdrawal or calendar method; one young couple (in their 20s) with one child had used condom before and are now using withdrawal and calendar method). The young couple mentioned that they did not like condom: for the husband, it was not pleasurable and for the wife, she was not satisfied and its use was painful to her.

INTRODUCTION

After going through the introductory remarks, the facilitators (one male and one female) oriented the participants on the subject of the discussion—that it would be about men's involvement in FP either in supporting their wives' use of FP or their own use of FP methods.

HIGHLIGHTS

The group was unanimous in saying that it is not difficult for men to support their wives to use an FP method because according to them life is difficult at present; and also because they (one male discussant in particular) had acquired an open mind as a result of his attendance in a training program. The group was in agreement that men's use of FP is not difficult because they were only using withdrawal, that the method particularly vasectomy was offered free, and that they wanted to help women avoid the ill-effects of their frequent pregnancies. For the young father-discussant, he said that he would undergo vasectomy once they achieve their desired family size of two because 'it was an expression of his love to his wife' and 'he was concerned of the health of the mother and child'. His wife was asked and she expressed that she has no objection to his decision.

Note: The pre-determined follow up questions, as so defined in the guide, clarifying additional dimensions of difficulties in men's support of their wives' FP method use, and men's use of FP methods were abandoned at this point, and we allowed discussants to say what they wanted to say. Thus:

One female discussant mentioned that in Barangay Sta. Cruz where they live, 90 percent of the couples are practicing family planning methods. When queried, 15 percent of the couples are using male methods and 75 percent female methods. (official barangay report shows that in 2004, 32 were pill users, 50 were ligated, 11 were vasectomized, and one was condom user). Her worry—shared by another female discussant—was that the barangay's elementary school would be closed due to lack of enrollment because of small family size. She then elaborated that the elementary students enrolled in the school come from other barangays.

When asked for explanations for such a high prevalence of FP method use in the barangay, discussants said that the practice runs in the family (one was telling about her father having been vasectomized), that there have been many groups implementing

family planning services in their barangays (like the Iglesia ni Cristo or medical missions), and that there is a clinic in their barangay providing FP methods. They also said that FP method use is high in their area because of life's difficulties, their previous experience of having come from big families, their families' desire for their children to complete schooling, and due to their awareness of the adverse consequences (such as having damaged uterus) that pregnancy after pregnancy poses to women.

When prompted, some discussants agreed that their barangay is unusual in the municipality in terms of its high FP method use prevalence. They were then asked this broad question: if you were to promote FP method use in other barangays where FP method is low, what would you suggest? The following were offered:

1. Share information and experience with them.
2. Emphasize that life is better or children are healthy if FP methods are used. Show examples (eg, children are schooling, can afford to pay hospital once sick).
3. Offer services for free.
4. Method users (like those vasectomized) should serve as models.
5. Dispel myths and misconceptions (that vasectomy for example restricts erection).
6. FP methods should be promoted by someone who is educated..

The discussants did not believe that laws are necessary to encourage use of FP methods. According to them, if the couples will use or not use, no law shall come in between. The young father-discussant cited that having a two-child policy, a perceived provision of a legislative bill under discussion, will result in abortion.

On the question of whether permanent method should be used once fertility goals are reached, the group was silent on this issue except for one who said that it should be opted (as an expression of love). As to whether it would be the male or female who should adopt it, one female discussant was vocal in expressing that it would be contingent on whether the male or female is engaged in heavy work.

The facilitators then summarized the major points to the participants for concurrence or modification. Then they asked whether or not the participants had other concerns and questions. Then they told discussants that the activity is over.

Note: Of the three couples, only three were consistently participative: two women and one young man. The others except for expressing a line or two were quiet throughout the discussion despite prodding from the facilitator.

DOCUMENTATION OF FGD IN BAGO CITY ON FEBRUARY 17 2005

PROFILE OF RESPONDENTS: Four Couples

	Couple 1		Couple 2		Couple 3		Couple 4	
	Husband	Wife	Husband	Wife	Husband	Wife	Husband	Wife
Age:	35	33	45	37	34	35	39	38
Occupation:	Farmer	Housewife	Farmer	Housewife	Street Food Vendor(Asal)	Housewife	Vendor	Housewife
No. of Children:	5	5	3	3	4	4	4	4
FP Method Used before Vasectomy:	None	None	-	Pills	-	IUD	Condom	Pills
Year Vasectomized:	2002	-	2002	-	2002	-	2003	

- All respondents came from rural areas.
- The respondents have 'unstable work'(farming/ 'remedyo-general' or 'erratic income');.
- Couple one and couple two are neighbors (same place); and also same with couple three and couple four (neighbors).

Pierra Fuentespina
Facilitator

SUMMARY: FGD
February 17, 2005
Bago City

1. How did you learn about vasectomy?

They learned of vasectomy from BHWs. The latter went to their house. At times, midwives and friend were also their source of information on vasectomy. For some, they learned of vasectomy from male friends & neighbors who were vasectomized.

Do you know other men who were already vasectomized?

Respondent A: Yes, 30 approximately – friends
Respondent B: Yes, 5 neighbors
Respondent C:Yes, 5 (family & friends)

2. What made you decide to have a vasectomy?

Primarily, what made them decide to undergo vasectomy was their family's financial/ economic status – subsistence living, unstable job, growing number of children. They are concerned in supporting their family in the future. They are bothered or afraid of having more children considering the present situation vis-à-vis their status.

The information about vasectomy given by BHWs and the testimony of their friends and relatives influenced their decision. The City Health Office made available the service (vasectomy) for free, which made vasectomy accessible for them and further encourage them.

3. How did you decide : by yourself, in consultation with wife, and or in consultation with others?

Basically, the husband decides for themselves in consultation with their wives. The couples had deliberate discussions in comparing vasectomy with ligation or with using contraceptives.

The couples agreed that ligation is more hazardous. It would impair or greatly affect a woman's health, preventing her from doing her regular household chores, taking care of the children, and attending to family's needs. The wife has to rest for a long time to regain enough strength, unlike in vasectomy the husband can go back to work right after the operation. The couples also expressed that ligation is more painful than it is with vasectomy. The couples also said that the effects of using contraceptives are uncertain.

4. How long did it take you to decide?

Respondent A – one week after he (and his wife) has known about vasectomy
Respondent B – six months after
Respondent C – 2 weeks after
Respondent D – 1 year after

Respondents A and C decided quickly because they were really convinced with the idea of vasectomy and its long term benefits. They consulted their families and they agreed to it.

Respondents B and D, on the other hand, took a very long time to decide because they were really assuring themselves of the effect of vasectomy. They observed their friends who were already vasectomized and after such a long time , when finally convinced, decided to have vasectomy.

5. What were the obstacles to your getting a vasectomy?

The respondents did not encounter any obstacles before and after the operation. There were issues like vasectomy would make them less of a man, but these did not matter to them. These did not even bother them. All they were concerned about was vasectomy would be very beneficial for their family especially with their children. Vasectomy for them is very favorable in terms of cost since it is rendered free by the city local government , and in effect, provides long- term benefits.

6. Experience with the procedure: What went well? Where there any problems?

The respondents all shared that they did not have any problem during the procedure. The operation just went well. They did not feel any fear to undertake the operation and neither felt pain during the operation.

7. Recovery process: What went well? Where their any problems?

There were really no serious problems, except that the respondents felt some numbness but it is tolerable. They said that perhaps the numbness was just a natural effect of the operation.

8. How has vasectomy affected your relationship with your wife, and relationships with your friends and family?

Vasectomy did not really affect the respondents' sex-life or sex drive. Erection was still the same, however there were changes in the quality of sperms or semen (lesser in volume/ quantity and less saturated). Despite this, everything still remained the same. There was even greater satisfaction now because the wives did not fear pregnancy. The frequency of sex (per day) even increased. Couple D jokingly said that now they can have sex 2-4 times a day. Respondent C expressed that they can just have sex anytime without fear or hesitation.

All the couples said that their relationship as husbands and wives are much closer and better now than it was before.

9. What are the things that can be done to encourage other men to adopt vasectomy?

The respondents also agreed that they should set themselves as examples to others. They would testify and would be willing to share their experiences to others after being

vasectomized. especially to their friends and relatives. In other words, they would help in the information dissemination. Also, they would give their testimonials of what went during their operations and its effect thereafter by simple conversations with others. They would also encourage other men to attend seminars and be practical.

10. Why do you think you were willing to do vasectomy when so many men are not?

Primarily because of their families' financial and economic status. Considering the present condition, they are definitely not capable of supporting or raising a large family. The husband also said that they want to attend to the needs of their families better and that they want to provide a better future for their families, especially their children. The husbands also believed that it's about time for the men to take steps on family planning. Respondent A even said that he loves his wife so much that he doesn't want her to suffer the pain of ligation, that's why he underwent vasectomy himself.

11. If you were to promote vasectomy to other men and women, what would you suggest?:

- To attend/ participate in seminars about family planning and to share their testimonies there (like what respondent A is doing);
- To encourage more information dissemination or campaigns, especially through the media (TV Advertisements);
- BHWs to continuously promote vasectomy;.
- To lead by example for others..

12. Would you recommend vasectomy to others?

The respondents would definitely recommend vasectomy to others. In fact, they are already doing it.

Respondent A has recommended vasectomy to over 500 people and approximately 70 percent - 80 percent of which has undergo vasectomy. (Since he is participating in seminars)

Respondent B has recommended it to almost 50 people and 3 decided to have vasectomy.

Respondent C has recommended to 10 people and 2 are now vasectomized.

Respondent D has recommended to 15 people and 6 are now vasectomized.

Reasons why others does not want:.

- Would affect their health (would become weak and can no longer perform their daily work).
- Would be castrated, will become impotent and loss of fertility, lesser libido and would no longer enjoy sex;

- Fear that they would become uncomfortable after being vasectomized and such that it can no longer be put back or regain it. (don't want to regret in the future if something bad happens).

Final Counselling (Pre-Op)

Some questions raised:

1. Will it not affect my work after the operation?
   Will I still have the strength after the operation?
2. Vasectomy VS Ligation
3. (Tricycle drivers) Can I drive right after the operation? (Considering the heat from the engine)
4. What are some side-effects?

Clients:

1) Rolando -28 years old., 3 children, Tricycle Driver
2) Rolando – 41 years old, 7 children, farmer

Daisy Enriquez – family planning coordinator

Daisy assured the 2 Rolando's that vasectomy (the operation) would not affect their work. In fact, they can resume their work even after the operation but they were advised to take some rest first. They were also advised to shave their pubic region to avoid infection.

The two were very eager to undergo the process and there were no sign of hesitations.

During the Operation:

*Rolando 1
- was really sure of what he was getting into;
- was not afraid, very eager;
- did not feel any pain;
- even requested if he could see how vasectomy is done;

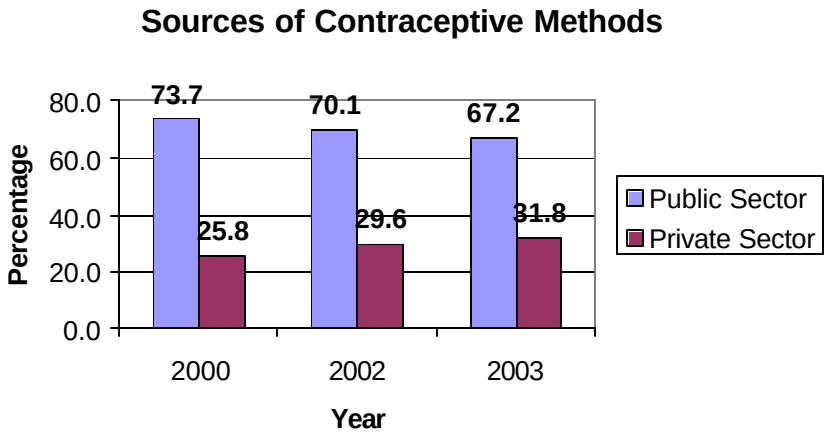
* I was not able to witness Rolando 2's operation. I went upstairs to assist in the FGD. I didn't have the time to note some post- op reactions from Rolando2's operation.

APPENDIX I

TABLES AND FIGURES FOR SECTION VI

TABLES AND FIGURE FOR SECTION VI

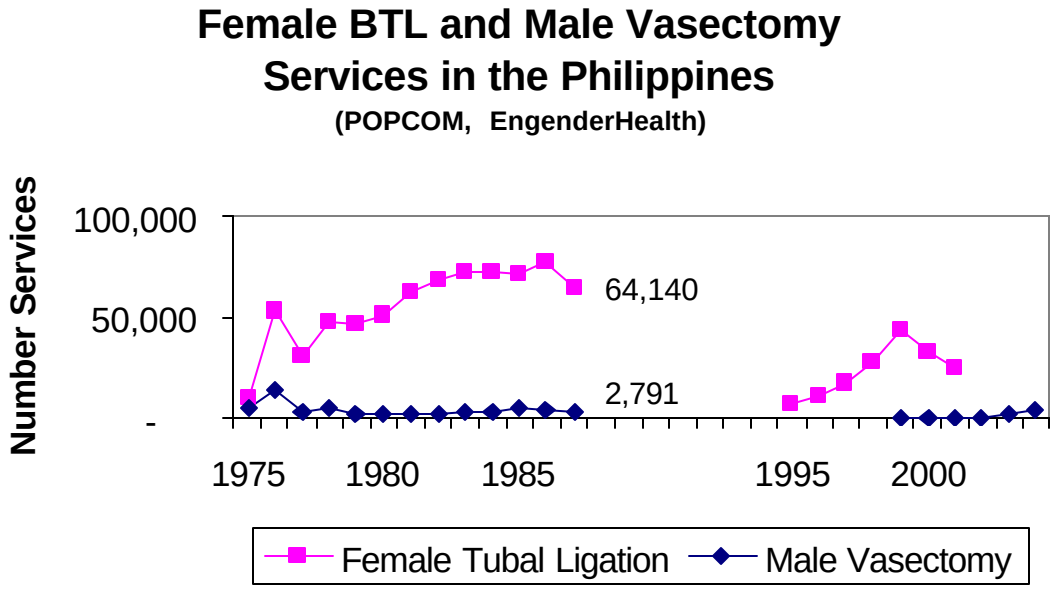
Figure 1



(1) Source of FP Services in the Philippines from 2000 to 2003 (NDHS, 2003)

Figure 2

(2) Female BTL and Male Vasectomy Services Over the Last 30-years (Despabiladeras E, undated and EngenderHealth 2002)



(3) Figure 3. List of Persons and Organizations Met for Male FP Service Issues

Stakeholder	Location	Male	Female
FP Clients	Monkayo, Compostela Valley (15Feb2005)	5	
	Sta. Cruz, Bagabag, Nueva Vizcaya (15Feb2005)	3	3
	Valencia City Health, Bukidnon (16Feb2005)	2	1
	Bago City, Negros Occidental (17Feb2005)	4	4
	Kaanib Members, Bukidnon (17Feb2005)	4	6
Private Sector FP Providers	Trade Union Congress of the Philippines (08Feb2005)	2	
	Family Planning Organization of the Philippines (08Feb2005)	1	3
	DKT Philippines, Inc. (09Feb2005)	2	1
	Save the Children Headquarters (11Feb2005)		1
	FriendlyCare Corporate HQ (10Feb2005)	1	2
	The Path Foundation (11Feb2005)		2
	WellFamily Midwife Clinic in Bangkal, Davao City and Board Chair (14Feb2005)	1	1
	Rivera Hospital in Panabo City, Davao del Norte (15Feb2005)		1
	Dr. Isamel Naypa (16Feb2005)	1	
Public Sector FP Providers	Davao del Norte Provincial Health Office (14Feb2005)	3	3
	Main Health Center in the Municipality of Braulio E. Dujali (14Feb2005)	5	2
	City Health Office of Panabo (14Feb2005)		1
	Nueva Vizcaya Provincial Health Office (14Feb2005)	2	2
	Bambang Municipal Health Office (14Feb2005)	9	
	Monkayo Municipal Health Office, Compostela Valley (15Feb2005)	1	2
	Valencia City Health Office, Bukidnon (16Feb2005)	1	1
	Malabybalay City Health , Bukidnon (17Feb2005)		2
	Bago City Health Office, Negros Occidental (17Feb2005)		4

Policy Makers and Funding Partners	**USAID Office of Population, Health and Nutrition (07Feb2005)**	**1**	**6**
	Commission on Population (07Feb2005)		**4**
	Academy for Educational Development (AED) The Social Acceptance Project (08Feb2005)	**5**	**6**
	Former Secretary of Health Alberto Romualdez, Jr. (10Feb2005)	**1**	
	Department of Health, Family Planning Service (10Feb2005)	**1**	**2**
	Philippine Health Insurance Corporation	**1**	
	The UNFPA (United Nations Population Fund) Country Office (10Feb2005)	**1**	**1**
	The Management Sciences For Health (MSH) LEAD Local Enhancement and Development (LEAD) for Health Project (10Feb2005)	**3**	
	Presentation Session to USAID Office of Population, Health and Nutrition and other Cooperating Agencies (24Feb2005)	**4**	**11**
Total		**65**	**71**

(4) Figure 4 Example of CBMIS Results Featuring FP Unmet Need Data Collected in the 4th Quarter of 2004 (Malaybalay, 2005)

CBMIS Latest Report from Malaybalay City - FP Survey	
MWRA with an FP method	14,715
MWRA not using FP	17,458
MWRA wanting to use Temporary FP	430
MWRA wanting to use BTL	24
MWRA wanting to use NSV	1
MWRA with an FP method, but not satisfied with method	20

Figure 5

(5) TUCP FP-RH Performance from January 2001 to December 2003 (2005)

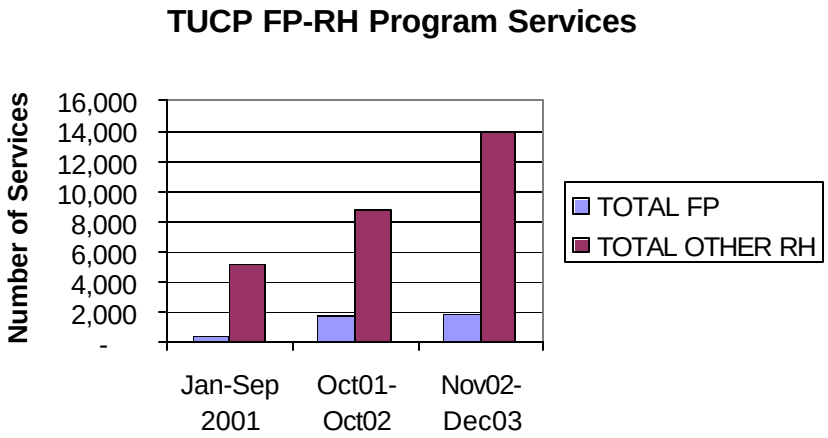


Figure 6

(6) FP New Acceptors in Nueva Vizcaya from 1999 to 2004 (2005)

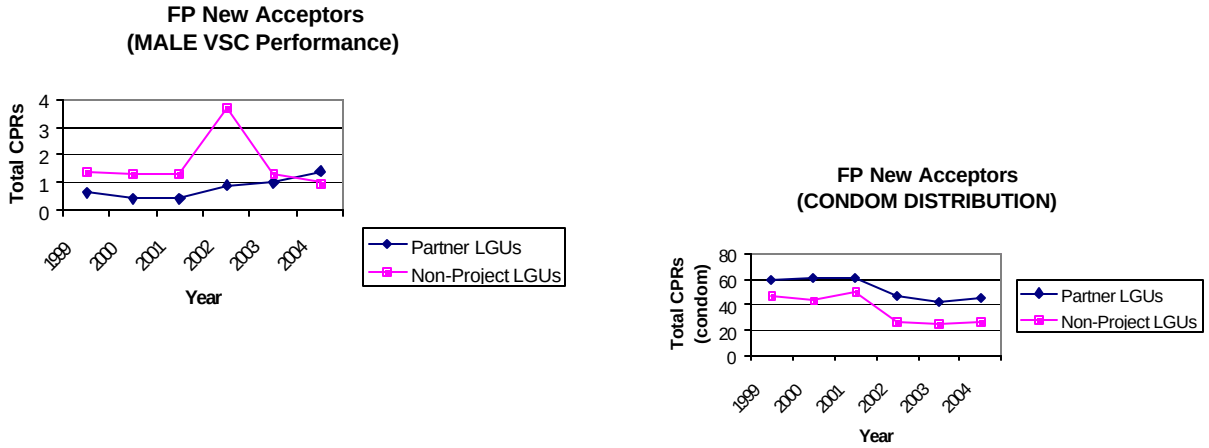


Figure 7

(7) Outstanding NSV Motivation in Banlag, Based on Valencia City Performance from January 2000 to January 2005 (Valencia City, 2005)

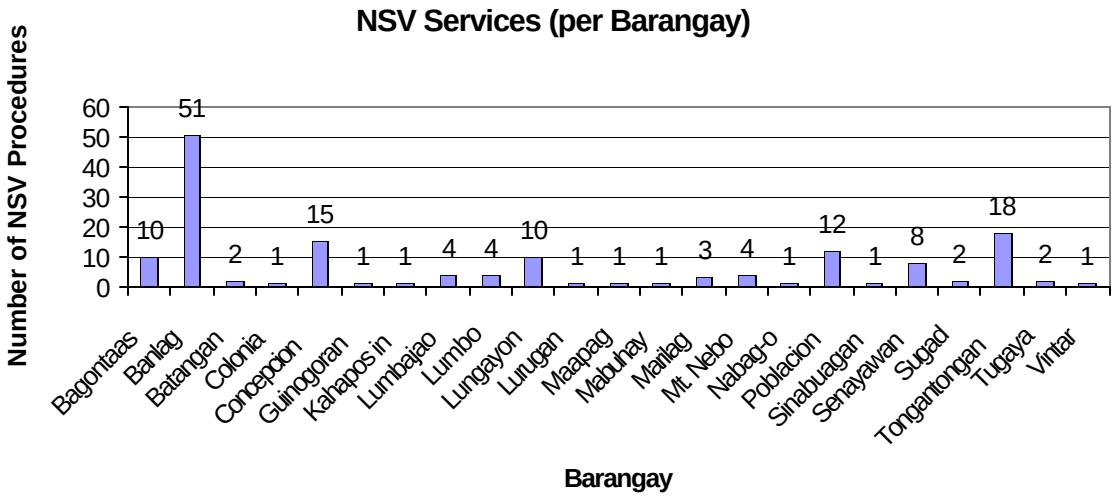


Figure 8

(8) FP Services in Davao del Norte from 2000 to 2003 (2005)

	New Acceptors of Family Planning									
	pills	IUD	DMPA	BTL	NSV	condom	LAM	NFP	SDM	TOTAL
Year										
2000	2,657	1,333	2,087	194	164	1,141	6,881	1,678	-	16,135
2001	2,314	928	1,829	212	158	1,041	6,413	918	-	13,813
2002	2,960	1,139	1,821	596	212	894	4,976	483	-	13,081
2003	2,703	1,393	1,892	562	151	1,041	4,773	421	109	13,045

Figure 9

(9) FP Method Mix in Davao del Norte for the Period from 2000 to 2003 (2005)

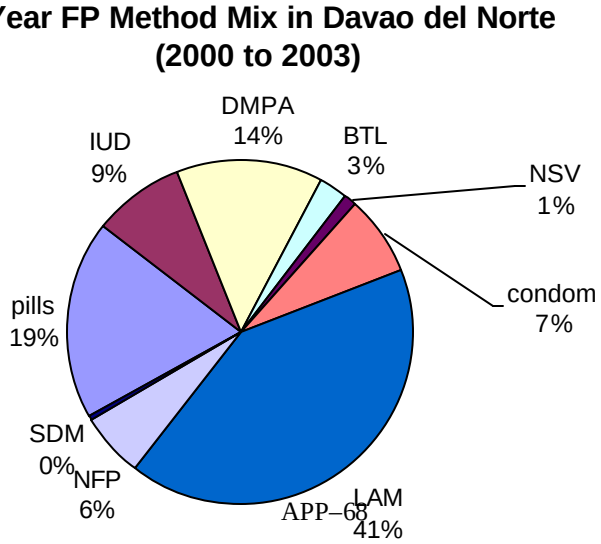
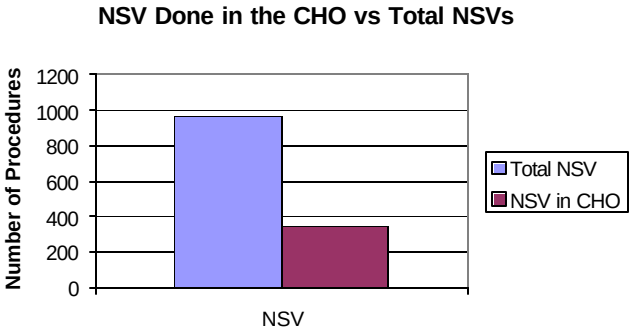


Figure 10

(10) Comparison of the Number of VSC Procedures Done in Primary Health Care and Hospital Setting from 2000 to 2004 (Bago City Health Office, 2005)



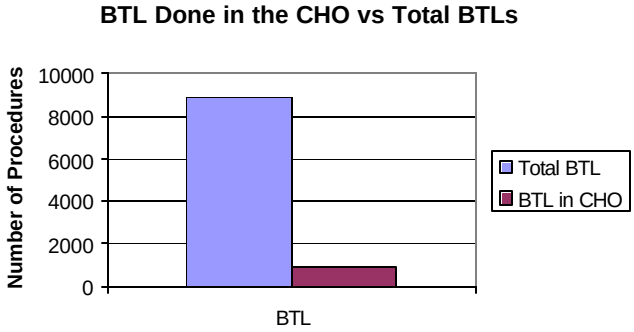
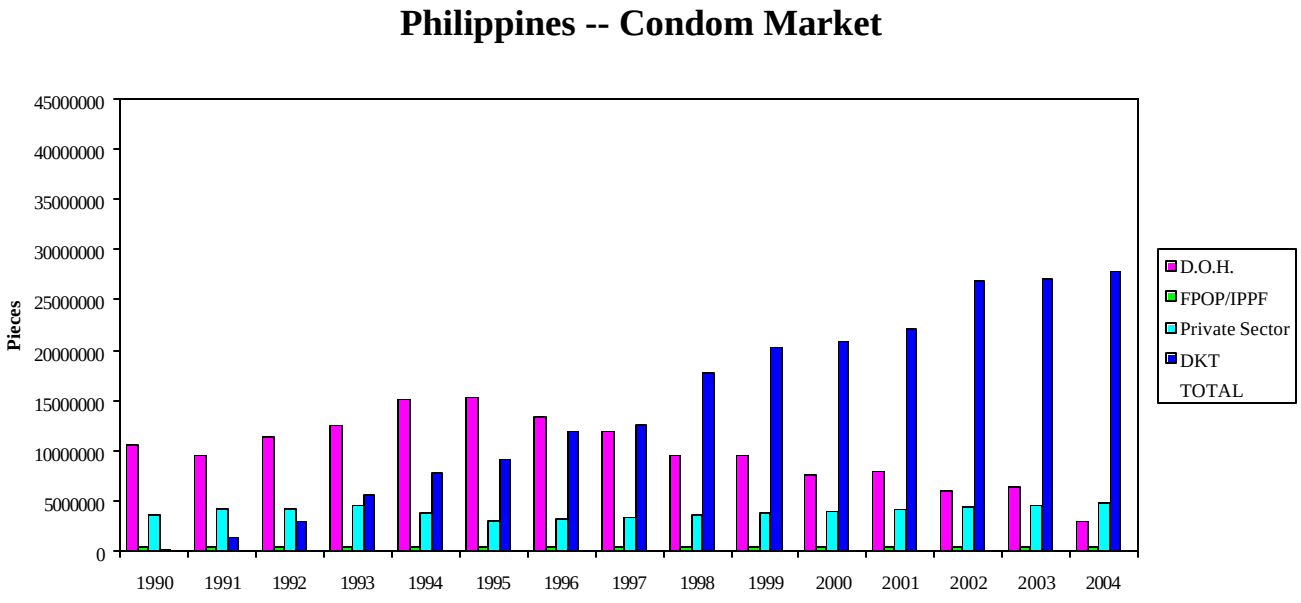


Figure 11

(11) Condom Supplies from 1990 to 2004 (DKT 2005)



APPENDIX J

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REFERENCES

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